November 2, 2016

Phyllis C. Borzi, Assistant Secretary of Labor
Employee Benefits Security Administration (EBSA)
200 Constitution Ave., NW, Suite S-2524
Washington, DC 20210

RE: RIN 1210-AB63 EBSA-2016-0010: Annual Reporting and Disclosure

Dear Assistant Secretary Borzi:

On behalf of Freedman HealthCare (FHC) and the State of Arkansas Insurance Department, I am pleased to submit this letter in response to the Department of Labor's (DOL) proposed rule regarding regulations as they relate to annual reporting of employer benefit plans governed by the Employee Retirement Income Security Act of 1974, as amended (ERISA).

FHC is the leading advisory firm for states creating and operating all-payer claims databases (APCDs), and FHC has worked with the large majority of state APCD initiatives since 2006. Our expertise extends into all aspects of development, implementation and operations, including consultation on legislation, regulation and building relationships between state agencies and commercial payers and data submitters. We regularly consult with state agencies regarding the use and analysis of data derived from APCDs, and we are experienced with the array of reporting and analytic opportunities stemming from robust data resources.

The State of Arkansas has an APCD initiative that commenced in 2014 and via Act 1233 of 2015 and Arkansas Insurance Department Rule 100, and we are well on our way to fully implementing an all-payers claims database. This being the case we have closely observed the ERISA preemption issue which was considered by the US Supreme Court in the *Gobielle v. Liberty Mutual*[1] decision. We have utilized the services of Freedman HealthCare throughout this process and are pleased to join their comment letter to the US Department of Labor, as the DOL moves forward in the process promulgating regulations in response to the *Gobielle* decision.

As policymakers, plan sponsors, and beneficiaries watch the health care system become increasingly complex and costly, and as the evidence documenting disparities in health care cost and quality continues to mount, we would like to thank the DOL for recognizing the importance of collecting additional data from self-insured employer benefit health plans governed by ERISA (hereafter, "ERISA Plans") and for requesting comments on the proposed rule. As you are well aware, the proposed rule is especially significant given the Supreme Court's recent decision in *Gobeille*.

This comment will highlight the benefits of expanded DOL reporting requirements for ERISA plans and provide specific suggestions as to how those requirements may be best applied. Our key points are as follows:

[1] *Gobeille v. Liberty Mutual Ins. Co.*, 577 U.S. Opinion of the Court (2016)

- APCDs are valuable public assets to serve many current and future needs, including protecting plan sponsors and beneficiaries from poor quality and high costs. Further, the value obtained from APCDs is not obtainable from existing data sources or others that may be reasonably proposed;
- Although the *Gobeille* decision significantly impairs the value of APCDs by curtailing state authority over collecting ERISA Plan data, the DOL has the authority and opportunity to remedy this injury. In addition, DOL can further advance the cause of administrative efficiency by incorporating a new national standard ("Common Data Layout") for data collection as part of its proposed rule;
- The DOL should expand the proposed rule to require regular submission by ERISA Plans of detailed eligibility, claims and provider information to APCD states. The rule should incorporate the Common Data Layout that has been collaboratively created by state and industry participants as a national standard;
- The DOL should also create standards for data quality and timeliness, as well as establish a long-term process for ensuring that the Common Data Layout remains updated and viable.

Sixteen states currently operate APCDs which systematically collect detailed health plan data, including: member eligibility information; medical, behavioral health, pharmacy and dental claims (including the actual payment amounts for all services); and provider information. APCDs contain cross-payer and cross-setting information that is unavailable from other data sources and is critical for work in pursuit of the Triple Aim of better care, healthy people/healthy communities, and affordable care.[2] For example, hospital-discharge datasets contain inpatient hospital information but limited or no information on outpatient care or the amounts paid for services. Similarly, Medicare data provides insight for Medicare beneficiaries only, and since Medicare uses administered pricing, the Medicare data sets alone shed little light on market-wide health pricing and other economic questions. By virtue of their rich and broad data, APCDs support many public health, policy, performance improvement, and consumer empowerment goals. The table below highlights several relevant examples.

Role	Examples
Public Health	• Incidence and prevalence of illnesses and injuries • Disparities in health and treatment, by age, gender, socioeconomic status, geography and payer or coverage type • Monitoring of topics of interest, such as cancer, hepatitis C, opioid prescribing, treatment of overdoses, utilization of inpatient and outpatient substance abuse services, etc.
Market reform and consumer empowerment	• Price transparency tools • Comparative quality of providers • Modeling alternative payment models • Examining consumer out-of-pocket expenditures
Market function and health economics	• Medical inflation • Market share of insurers and providers • Provider price variation

[2] AHRQ National Quality Strategy http://www.ahrq.gov/workingforquality/reports/annual-reports/nqs2011annlrpt.pdf as required under Affordable Care Act §3011

	• Analysis of effects of proposed mergers or expansions • Quantifying cross-subsidization by socioeconomic status • Evidence-based health care policy development
Performance measurement and improvement	• Quality measurement and reporting • Tracking patient outcomes of drugs, devices, procedures • Population health management • Predictive modeling over time and across payers • Practice pattern variation • Risk-adjusted total medical expense • Accountable Care Organization performance and benchmarking • Hot spotting • Utilization rates • Actual vs. expected access to care as affected by consumer out-of-pocket expenditures
Research	• Rare diseases • Health services research • Evaluation of aspects of health care reform • Clinical effectiveness research • Cost effectiveness analysis • Impact of EHRs

Across all of these priority areas, APCDs complement and extend existing data sources by bringing the power of large numbers to understanding American health, health insurance, and health care delivery. The need for a comprehensive source of detailed cross-setting care data—exactly what is contained in APCDs—only grows in importance as health care continues its rapid transformation away from inpatient hospital care and towards outpatient medical and behavioral health settings.

To fully realize their potential, APCDs must include data from the large majority of beneficiaries. Until the *Gobeille* decision, APCDs were able to collect data for the vast majority of commercially insured individuals, whether enrolled in ERISA self-insured plans, ERISA fully-insured plans, health insurance exchange plans, or other types of plans. As a result of the *Gobeille* decision, APCDs have essentially lost access to the data of over half of the commercially insured population. A data loss of this size badly weakens the power and insight available in APCDs. In particular, it sharply restricts the ability of APCD data to help ERISA Plans, their sponsors and beneficiaries.

DOL, by virtue of its authority under PHSA §§ 2715A and 2717 and ERISA §§ 104 and 505, has the opportunity and authority to remedy the data loss that has resulted from *Gobeille*. Furthermore, by adopting a national data standard for ERISA plan submission, the DOL can fulfill the Supreme Court's stated desire for a standardized and simplified approach to this data collection: *"The central design of ERISA . . . is to provide a single uniform national scheme for the administration of ERISA plans without interference from laws of the several States even when those laws, to a large extent, impose parallel requirements.[3]"*

[3] 577 U. S. Opinion of the Court (2016), p 13

We urge that the DOL's final rule require detailed eligibility, claims and provider data to be submitted by all ERISA Plans that have 100 participants or more, as described in the Common Data Layout that is being collaboratively created by various stakeholders and is based upon a version distributed by the Center for Health Care Transparency[4]. While we appreciate the language of the proposed rule for seeking more data than is currently collected, we believe the proposed Schedule J will fail to secure the data needed to achieve the benefits described above.

Timeliness is always important in data analytics, and any process that would unnecessarily delay transmission of data to the states would reduce its value. Therefore, we believe that the final rule should require that ERISA Plans submit their data directly to relevant APCD states.

A further benefit of such a DOL final rule would be widespread adoption of the new data standard. Based upon our experience with state-administered APCDs, it is likely that a data standard for self-insured ERISA Plans will likely become a *de facto* standard for other commercial insurance plans, including fully-insured ERISA plans and others.

Lastly, we recommend that DOL include provisions to ensure consistency and continuity of the new data standard. DOL should provide minimum thresholds for the completeness and accuracy of the data elements contained in the Common Data Layout. For example, the numeric codes to indicate the service provided to a patient might need to be 100% completed and 95% accurate. These thresholds could be included explicitly in the rule or incorporated by reference to a work product of the collaborative workgroup that has created the Common Data Layout. DOL should set a schedule of reporting frequency that supports effective use of the data. At first, that could be quarterly data submissions, with monthly submissions required thereafter. DOL should also provide for a process to periodically update the Common Data Layout, perhaps delegating that responsibility to an advisory committee consisting of representative stakeholders including state APCDs, state policymakers, consumers, insurers or third-party administrators, experts in health claims data, and health services researchers.

We believe that these suggestions will help bring about not only an effective restoration of the analytic power of APCDs, but also substantial administrative simplification (for states, ERISA Plans, and others), while lowering the costs of creating new APCDs for the large areas of the country that have not yet created one, thus expanding the use of a powerful tool for the pursuit the Triple Aim for all Americans.

Thank you for your consideration of these comments.

Sincerely,

John D. Freedman, MD, MBA
President
Freedman HealthCare LLC

Daniel W. Honey
Deputy Commissioner
Arkansas Insurance Department

[4] A copy of the Common Data Layout is included with the comments submitted separately by the National Academy of State Health Policy