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State Data Collection and Reporting Requirements in the Affordable Care Act

The Affordable Care Act (ACA) and its amendments, including the Health Care and Education Reconciliation Act, set up multiple reporting and data collection requirements for states. The purpose of this brief is to outline the statutory requirements under the ACA related to data collection and reporting. This brief does not include requirements imposed by regulations promulgated under the statute because the many of the regulations are in proposed form and may be significantly modified before becoming binding. States may be interested in this information for two reasons. First, this brief provides a starting point for compliance efforts. Second, this brief sensitizes states to the data-gathering potential of implementation efforts and allows states to anticipate how they might like to design health reform infrastructure to fully develop this potential.

One significant limitation states may face in maximizing the value of data gathered through the Exchange is that the statute limits what information may be collected from health care consumers seeking coverage through the Exchanges. Exchanges may only require consumers

> *"to provide . . . the information strictly necessary to authenticate identity, determine eligibility, and determine the amount of credit or reduction."*[1]

The final Exchange rule gives minimal clarification providing that this section of the Act "does not prohibit the collection of demographic data,"[2] but that Exchanges may not collect information "beyond the minimum necessary to support eligibility determinations for the Exchange and insurance affordability programs."[3] Similarly, the Act only allows states to use information collected by Exchanges to "ensur[e] the efficient operation of the Exchange."[4] Evaluating implementation progress may fall into this category. States will most likely need to identify and collect alternative sources of data and information to meet their federal reporting obligations and for state-level evaluation and monitoring purposes.

[1] ACA § 1411(g)(1).
[2] Dep't Health & Human Servs., Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers, Final Rule, Interim Final Rule 122 (to be codified at 45 C.F.R. Parts 155, 156, & 157).
[3] *Ibid.* at 287
[4] ACA § 1411(g)(2)(A).

Support for this work was provided by the Office of the Assistant Secretary for Planning and Evaluation (ASPE)

Summary of Statutory Requirements: In general, states are required to collect information in five specific areas under the ACA. Each of these areas is identified and described below.

(1) Verification of Eligibility (ACA §§ 1411(c); 1311(d)(4)(H))

In order to verify individual identities and ensure that the state has accurately determined individual eligibility for public programs, states are required to submit certain information about individuals' citizenship and financial situation (i.e. the household modified adjusted gross income) to the Department of Health and Human Services and to the Department of the Treasury.

(2) Reporting on Exchange Operations (ACA §§ 1313(a)(1); 1311(d)(7))

The state must collect and publish information on the financial activities of the exchange, including annual operating costs and amounts lost to fraud, abuse and waste.

(3) Certification of Qualified Health Plans (ACA § 1311(e)(3)(A))

Because plans sold in the exchange must be certified as "qualified health plans," states, through their health insurance exchanges, must develop and implement a procedure for certifying health plans and assign them a rating based on HHS regulations. These regulations require "qualified health plans" to, among other requirements, refrain from selecting for healthy enrollees, ensure a sufficient choice of providers, meet certain quality accreditation standards, and use a standardized enrollment form. To allow the health insurance exchanges to certify plans, insurance offerors seeking to have plans certified as "qualified health plans" must provide must provide certain information to the exchanges.

(4) Reporting Related to Medicaid (ACA §§ 2001(d)(1)(C); 2002(a); 2401; 2701)

States must also provide HHS with information related to Medicaid including information about annual enrollment and operations of the state's Medicaid program, the state's plan for measuring income eligibility, information about the operation of a basic health plan, home- and community-based services, as well as an annual report on the quality of Medicaid services provided.

(5) Reporting on Statewide Needs and Communities at Risk (ACA § 2951)

As a condition of receiving certain federal funds to support maternal and child health home visiting programs, States were required to conduct a one-time statewide health needs assessment to identify communities particularly at risk for certain risks to maternal and child health including, for example, incidence of low birth weight. States were required to report the results to HHS.

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The detailed statutory language requiring data collection or reporting in each of these five areas is reproduced in the following section.

Detailed Tables of Statutory Requirements: This section provides the statutory text establishing the state data collection and reporting requirements described above. Tables are organized into the following five general areas: (1) verification of eligibility, (2) reporting on exchange operations, (3) certification of Qualified Health Plans, (4) reporting related to Medicaid, and (5) reporting on statewide needs and communities at risk.

(1) Verification of Eligibility

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
§ 1411(c) codified at 42 USC § 18081	VERIFICATION OF INFORMATION CONTAINED IN RECORDS OF SPECIFIC FEDERAL OFFICIALS. (1)INFORMATION TRANSFERRED TO THE SECRETARY.—An Exchange shall submit the information provided by an applicant under subsection (b) to the Secretary for verification in accordance with the requirements of this subsection and subsection (d).	Exchange	Secretary of HHS	• Date of birth • Address • Income *(potentially*[*]*)* • Age *(potentially*[*]*)* • Citizenship • Family size • Amount of tax credit • Individual exemption status
§ 1311(d)(4) codified at 42 USC § 18031	An Exchange shall, at a minimum— ….. (H)Transfer to the Secretary of the Treasury— (i) A list of the individuals who are issued a certification . . . including the name and taxpayer identification number of each individual; (ii)The name and taxpayer identification number of each individual who was an employee of an employer but who was determined to be eligible for the	Exchange	Secretary of the Treasury	• Individual exemption status • Insured/ uninsured status of employees • Receipt of premium tax credit • Employees who have changed employers • Cessation of

[*] States have the option of using an eligibility form developed by HHS or developing their own application and having it approved by HHS. ACA § 1413(b)(1). Because HHS has not released regulations on the content of this form and states appear to not yet have developed their forms for approval, it is unclear at this point exactly what information will be available to the Exchanges.

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Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
	premium tax credit . . . (iii)The name and tax payer identification number of each individual who notifies the Exchange . . . that they have changed employers and of each individual who cases coverage under a qualified health plan during a plan year (and the effective date of such cessation)			coverage
§ 1401(a) codified at 26 USC § 36B	(f)(3) . . . Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange . . .) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange: (A)The level of coverage described in section 1302(d) . . . and the period such coverage was in effect. (B)The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act. (C)The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act. (D)The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy. (E)Any information provided to the	Exchange	Secretary of the Treasury	• Individual's level of coverage • Total premium amount • Amount of premium credit or reduction • Income (*potentially*[*]) • Level of coverage • Individuals insured under a single policy

[*] States have the option of using an eligibility form developed by HHS or developing their own application and having it approved by HHS. ACA § 1413(b)(1). Because HHS has not released regulations on the content of this form and states appear to not yet have developed their forms for approval, it is unclear at this point exactly what information will be available to the Exchanges.

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Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
	Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit. (F)Information necessary to determine whether a taxpayer has received excess advance payments			

(2) Reporting on Exchange Operations

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
§ 1313(a)(1) codified at 42 SC § 18033	. . . An Exchange shall keep an accurate accounting of all activities, receipts, and expenditures and shall annually submit to the Secretary a report containing such accountings.	Exchange	Secretary of HHS	• Exchange expenditures • Exchange activities • Exchange receipts
§ 1311(d)(7) codified at 42 USC § 18031	An Exchange shall publish the average costs of licensing, regulatory fees, and other payments required by the Exchange, and the administrative costs of such Exchange, on an Internet website to educate consumers of such costs. Such information shall also include monies lost to waste, fraud, and abuse.	Exchange	Public	• Average costs of licensing, regulatory fees and other payments • Exchange's administrative costs • Amount lost to waste, fraud and abuse

(3) Certification of Qualified Health Plans

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
§ 1311(e)(3)(A) codified at 42 SC § 18031	IN GENERAL.—The Exchange shall require health plans seeking certification as qualified health plans to submit to the Exchange, the Secretary, the State insurance commissioner, and make available to the public, accurate and timely disclosure of the following information: (i) Claims payment policies and practices. (ii) Periodic financial disclosures. (iii) Data on enrollment. (iv) Data on disenrollment (v) Data on the number of claims that are denied. (vi) Data on rating practices. (vii) Information on cost-sharing and payments with respect to any out-of-network coverage.	Health plans seeking certification as qualified health plans	-Exchange -Secretary of HHS -State insurance commissioner -public**	• Claims payment policies and practices • Periodic financial disclosures • Data on disenrollment • Data on enrollment • Data on # of claims denied • Data on rating practices • Information on cost-sharing and payments for out-of-network coverage

(4) Reporting Related to Medicaid

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
§ 2001(d)(1)(C) codified at 42 USC § 396a(a)(75)	. . . beginning January 2015, and annually thereafter, the State shall submit a report . . . that contains— (A) The total number of enrolled and newly enrolled individuals in the State plan or under a waiver of the plan for the fiscal year, ending on September 30 of the preceding calendar year,	State	Secretary of HHS	• Count of Medicaid or Medicaid waiver new enrollees • # children, parents, nonpregnant adults, disabled individuals,

** The Exchange, the Secretary of HHS, the State insurance commissioner all appear to be entitled to the same information under this section of the ACA. *See* ACA § 1311(e)(3)(A) (failing to differentiate between these parties).

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
	disaggregated by population, including children, parents, nonpregnant childless adults, disabled individuals, elderly individuals, and such other categories or sub-categories of individuals eligible for medical assistance under the State plan or under a waiver of the plan . . . ; (B) A description, which may be specified by population, of the outreach and enrollment processes used by the State during such fiscal year; and (C) Any other data reporting determined necessary by the Secretary to monitor enrollment and retention of individuals eligible for medical assistance under the State plan or under a waiver of the plan.			elderly individuals newly enrolled in such programs • Outreach and enrollment strategies used
§ 2002(a) to be codified at 42 USC § 1396a (e)(14)	TRANSITION PLANNING AND OVERSIGHT.—Each State shall submit to the Secretary for . . . approval the income eligibility thresholds proposed to be established using modified adjusted gross income and household income, and if applicable, a State plan amendment establishing an optional eligibility category . . . to the extent practicable, the State shall use the same methodologies and procedures for purposes of making such determinations as the State used on the data enactment. . .	State	Secretary of HHS	• Income eligibility thresholds • Method for calculating MAGI
§ 2401 codified at 42 USC § 1396n	(k)(5)(B) DATA COLLECTION.—The State shall provide the Secretary with the following information regarding the provision of home and community-based attendant services and supports under this subsection for each fiscal year for which such services and supports are provided:	States participating in the Community First Option	Secretary of HHS	• Count of individuals receiving home and community-based services • Last year's count

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
	(i) The number of individuals who are estimated to receive home and community-based attendant services and supports under this subsection during the fiscal year. (ii) The number of individuals that received such services and supports during the preceding fiscal year. (iii) The specific number of individuals served by type of disability, age, gender, education level, and employment status. (iv) Whether the specific individuals have been previously served under any other home and community based services program under the State plan or under a waiver.			• # of individuals served by type of disability, education level and employment status • How such individuals previously received services
§ 2701 codified at 42 USC § 1320b-9b	(d)(1) ANNUAL STATE REPORTS.—Each State with a State plan or waiver approved under title XIX shall annually report (separately or as part of the annual report required under section 1139A(c)), to the Secretary on the— (A) State-specific adult health quality measurements applied by the State under the such plan, including measures described in subsection (a)(5); and (B) State-specific information on the quality of health care furnished to Medicaid eligible adults under such plan, including information collected through external quality reviews of managed care organizations under section 1932 and benchmark plans under section 1937.	States	Secretary of HHS	• Medicaid "adult health quality measurements" • State-specific quality of health care provided to Medicaid beneficiaries

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(5) Reporting on Statewide Needs and Communities at Risk[***]

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
§ 2951 codified at 42 USC § 711	(b) REQUIREMENT FOR ALL STATES TO ASSESS STATEWIDE NEEDS AND IDENTIFY AT RISK COMMUNITIES.— (2) IN GENERAL.—Not later than 6 months after the date of enactment of this section, each State shall, as a condition of receiving payments from an allotment for the Statue under section 502 for fiscal year 2011, conduct a statewide needs assessment (which shall be separate from the statewide needs assessment required under section 505(a)) that identifies— (A) Communities with concentrations of— (i) Premature birth, low-birth weight infants, and infant mortality, including infant death due to neglect, or other indicators of at-risk prenatal, maternal, newborn, or child health; (ii) Poverty; (iii) Crime; (iv) Domestic violence; (v) High rates of high-school drop-outs; (vi) Substance abuse (vii) Unemployment; or (viii) Child maltreatment; (B) The quality and capacity of existing programs or initiatives for early childhood home visitation in the State including— (i) The number and	States receiving federal funds for maternal and child health home visiting programs	Secretary of HHS	• Premature and low birth weight • Infant mortality • Cases of infant neglect • Poverty • Crime • Domestic violence • High school graduation rates • Substance abuse • Unemployment • Child maltreatment • # and type of individuals who receive early childhood home visitation services • State capacity to provide early childhood home visitation services and gaps in capacity • State's capacity for providing substance abuse treatment

[***] States subject to this requirement should have already submitted such reports to the Secretary of HHS.

Section of the Public Law	Statutory Language	Information From	Information To	Select Potential Data Points
	type of individuals and families who are receiving services under such programs or initiatives; (ii) The gaps in early childhood home visitation in the State; (iii) The extent to which such programs or initiatives are meeting the needs of eligible families described in subsection (k)(2); and (C) The State's capacity for providing substance abuse treatment and counseling services to individuals and families in need of such treatment or services.			