Transparency in Coverage Reporting by Qualified Health Plan Issuers (CMS-10572)

Appendix A – QHP Issuer Data Collection and Display

Section A – QHP Issuer Data Collection and Display Overview

This chart lists the specific data elements CMS proposes to collect and display for 2016 through 2018 and a description of the data elements. More detail on the data elements to be collected is provided in section B, below.

Data Collection Element Name	**Data Element Description**	**Year in which Collection of Element will Begin**
Issuer Name	The issuer's full legal name, as submitted in the Qualified Health Plan (QHP) application.	2016
Issuer D/B/A, if Applicable	Business name(s) under which issuer offers QHP(s) on the Federally-facilitated Marketplace, if different from Issuer Name.	2016
Issuer ID	The issuer's 5-digit Health Insurance Oversight System (HIOS) ID.	2016
Contact Name	The contact person on the issuer's staff who the Centers for Medicare and Medicaid Services (CMS) should contact with any questions regarding this data collection.	2016
Backup Contact Name	The backup contact person on the issuer's staff who CMS should contact with any questions regarding this data collection, in the event that primary contact is unavailable.	2016
Contact E-mail	The e-mail address for the contact name and backup contact.	2016
Contact Telephone	The telephone number for the contact name and backup contact.	2016
Claims Payment Policies and Practices and Other Information as Determined Appropriate by the Secretary	Issuers will provide one URL link to policies on their websites on: out-of-network liability and balance billing; enrollee claim submission; grace periods and claims pending; retroactive denials; recoupment of overpayments; medical necessity and prior authorization timeframes and enrollee responsibilities; drug exception timeframes and enrollee responsibilities[1]; explanations of benefits (EOBs); and coordination of benefits (COB).	2016 (optional), 2017 (required)
Claims Denials	The number of claims denied, the number of internal and external appeals filed, and the disposition of the appeals.	2017
Data on Disenrollment	Issuer-level disenrollment figures.	2017

Data Display Element Name	**Data Element Description**	**Year in which Display of Element will Begin**
Claims Payment Policies and Practices and Other Information as Determined	URL link to policies on issuer websites on: out-of-network liability and balance billing; enrollee claim submission; grace periods and claims pending; retroactive denials; recoupment of overpayments; medical necessity and prior authorization timeframes and enrollee responsibilities;	2016 for issuers that opt to submit a URL; 2017 for all issuers

[1] Not required for stand-alone dental plans

Appropriate by the Secretary	drug exception timeframes and enrollee responsibilities[2]; EOBs; and COB.	
Claims Denials	The number of claims denied; the number of internal and external appeals filed; and the disposition of the appeals.	2017
Periodic Financial Disclosures	QHP issuers currently submit financial information to the National Association of Insurance Commissioners (NAIC). CMS would link to prior calendar year issuer-level information about premiums, assets, and liabilities that the NAIC currently collects and displays, and which is currently publicly available. CMS would display this link in a public use file (PUF). No issuer submission is required.	2016
Data on Enrollment	CMS would provide issuer-level enrollment numbers as derived from HealthCare.gov. Data enrollment numbers will be based on the end of the prior calendar year's information. CMS will provide this information in a PUF. No issuer submission is required.	2016
Data on Disenrollment	Issuer-level disenrollment figures.	2017
Data on Rating Practices	CMS currently provides plan-level Unified Rate Review data that it collects annually and displays on Data.HealthCare.gov. No issuer submission required.	N/A; CMS currently displays this
Information on Cost-sharing and Payments for Out-of-network Coverage	HealthCare.gov currently links to an issuer's current year Summary of Benefits and Coverage (SBC). The SBC includes information on cost sharing, including cost sharing for out-of-network services. No issuer submission required.	N/A; CMS currently displays this
Information on Enrollee Rights under Title I	CMS currently provides this information on enrollee rights and protections on HealthCare.gov, which is available at https://www.healthcare.gov/health-care-law-protections/. No issuer submission required.	N/A; CMS currently displays this

Section B – Detailed Information on Data to be Collected

- **Claims payment policies and practices.**
  - Information provided on the QHP issuer's website should include issuer-level policies applicable to QHP enrollees on the following. QHP issuer reporting is optional for plan year 2016 and required thereafter. If a QHP issuer voluntarily provides this information on its website, it should submit one URL for this information and other information as the Secretary may require, which CMS will display in a PUF.

    Out-of-network liability and balance billing
    Description of the data element:
    - Balance billing occurs when an out-of-network provider bills an enrollee for charges – other than copayments, coinsurance, or any amounts that may remain on a deductible.

    Issuers will provide the following:
    - Information regarding whether an enrollee may have financial liability for out-of-network services.
    - Any exceptions to out-of-network liability, such as for emergency services.

[2] Not required for stand-alone dental plans

- Information regarding whether an enrollee may be balance-billed. Issuers do not need to include specific dollar amounts for out-of-network liability or balance billing.

Enrollee claims submission

Description of the data element:

- An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

Issuers will provide the following:

- General information on how an enrollee can submit a claim in lieu of a provider, if the provider failed to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.
- A time limit to submit a claim, if applicable.
- Links to any applicable forms.
- The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.

- **Other information as determined appropriate by the Secretary.**
  - Information provided on the QHP issuer's website should include issuer-level policies applicable to QHP enrollees on the following. QHP issuer reporting is optional for plan year 2016 and required thereafter. If a QHP issuer voluntarily provides this information on its website, it should submit one URL for this information and claims payment policies and practices, which CMS will display in a PUF.

Grace periods and claims pending policies during the grace period

Description of the data element:

- A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must provide an explanation of the 90 day grace period for enrollees with premium tax credits pursuant to 45 CFR 156.270(d).

Issuers would provide the following:

- An explanation of what a grace period is.
- An explanation of what claims pending is.
- An explanation that it will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period.

Retroactive denials

Description of the data element:

- A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Issuers would provide the following:

- An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.
- Ways to prevent retroactive denials when possible, for example paying premiums on time.

Enrollee recoupment of overpayments

Description of the data element:

- Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Issuers would provide the following:

- Instructions to enrollees on obtaining a refund of premium overpayment.

Medical necessity and prior authorization timeframes and enrollee responsibilities

Description of the data element:

- Medical necessity is used to describe care that is reasonable, necessary, and/or appropriate, based on evidence-based clinical standards of care.
- Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.

Issuers would provide the following:

- An explanation that some services may require prior authorization and/or be subject to review for medical necessity.
- Any ramifications should the enrollee not follow proper prior authorization procedures.
- A time frame for the prior authorization requests.

Drug exceptions timeframes and enrollee responsibilities

Description of the data element:

- Issuers' exceptions processes allow enrollees to request and gain access to drugs not listed on the plan's formulary, pursuant to 45 CFR 156.122(c).

Issuers would provide the following:

- An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.

- The time frame for a decision based on a standard review or expedited review due to exigent circumstances.
- How to complete the application.

Information on Explanations of Benefits (EOBs)
Description of the data element:

- An EOB is a statement an issuer sends the enrollee to explain what medical treatments and/or services it paid for on an enrollee's behalf, the issuer's payment, and the enrollee's financial responsibility pursuant to the terms of the policy.

Issuers would provide the following:

- An explanation of what an EOB is.
- Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).
- How a consumer should read and understand the EOB.

Coordination of benefits (COB)
Description of the data element:

- Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Issuers would provide the following:

- An explanation of what COB is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).

Issuer contact information
Description of the data element:

- Issuers would provide appropriate contact information so that CMS can follow up with the appropriate point of contact with the issuer in the event of any questions.

Issuer would provide the following:

- Main point of contact, phone number, and email address.

- **Claims Denials**
  - Starting with the 2017 plan year, issuers would provide to CMS information regarding denied claims. Issuers would provide:
    - The total number of claims denied in the preceding calendar year, for any reason, both as a number and a percentage of all claims submitted.
    - The number of internal coverage appeals filed by enrollees in the preceding calendar year, both as a number and a percentage

of all claims submitted (i.e., what percent of all claims submitted enrollees appealed).
    - The number of internal coverage appeals in which the initial denial is overturned, both as a number and a percentage of all internal appeals filed.
    - The number of external coverage appeals filed by enrollees in the preceding calendar year, both as a number and a percentage of all claims submitted (i.e., what percent of all claims submitted enrollees appealed externally).
    - The number of external coverage appeals in which the initial denial is overturned, both as a number and a percentage of all internal appeals filed.

- **Data on Disenrollment**
    - Starting with the 2017 plan year, issuers would provide to CMS information regarding disenrollment. Issuers would provide the total number of disenrollment's for the preceding calendar year, both as a number and a percentage of all enrollees.