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

Appendix A – QHP Issuer Data Collection

Data Element Name	Data Element Description
Issuer Name[1]	The issuer's full legal name, as submitted in the Qualified Health Plan (QHP) application.
Issuer D/B/A, if Applicable[1]	Business name(s) under which issuer offers QHP(s) on the Federally-facilitated Marketplace, if different from Issuer Name.
Issuer ID[1]	The issuer's 5-digit Health Insurance Oversight System (HIOS) ID.
Plan ID[1]	The issuer's 14-alpha-numeric ID.
Contact Name[1]	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.
Backup Contact Name[1]	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.
Contact E-mail[1]	The e-mail address for the contact name and backup contact.
Contact Telephone[1]	The telephone number for the contact name and backup contact.
Claims Payment Policies and Practices and Other Information as Determined Appropriate by the Secretary[1]	Issuers will provide one URL link titled "Transparency in Coverage" to policies on their main 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; explanations of benefits (EOBs); and coordination of benefits (COB), as explained in section IV of the Supporting Statement.
Issuer-Level Claims Data[1]	Issuers will provide: claims received; claims denied; internal appeals filed; internal appeals overturned; percent of internal appeals overturned; external appeals filed; external appeals overturned; and percent of external appeals.
Plan-Level Claims Denial[2]	Issuers will provide plan level claims denials based on the following denial categories: 1.) Referral or prior authorization required, 2.) Out of network provider/claims, 3.) Services excluded or not covered, 4.) Not medically necessary, excluding behavioral health, 5.) Not medically necessary, including behavioral health, and 6.) Other.

[1] Approved on June 16, 2016 OMB Control #0938-1310