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

Appendix B – QHP Issuer Data Display

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.
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 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.
Periodic Financial Disclosure[1]	URL link to NAIC web page listing issuer premium receipts, assets, and liabilities in dollar amounts.
Data on Enrollment[1]	Issuer-level enrollment numbers as derived from the Federally-facilitated Exchange (CMS data).
Data on Disenrollment[1]	Issuer-level disenrollment numbers as derived from the Federally-facilitated Exchange (CMS data)
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
Data on Rating Practices[1]	Unified Rate Review data file on Data.HealthCare.gov.

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

Information on Cost-sharing and Payments for Out-of-network Coverage[1]	Summary of Benefits and Coverage (SBC) on HealthCare.gov. To include language on out-of-network billing by requiring issuers to explain §156.230(e) and disclosure of gag clauses.
Information on Enrollee Rights under Title I[1]	URL to the enrollee rights and protections information provided on HealthCare.gov at https://www.healthcare.gov/health-care-law-protections/.