

Transparency in Coverage Reporting by Qualified Health Plan Issuers

Appendix B2 – PY24-PY25 QHP Public Use File

Issuers do not need to provide data elements marked with an asterisk (*), as CMS will provide those elements.

Data Element Name	Data Element Description
Issuers Name	The issuer’s full legal name, as submitted in the Qualified Health Plan (QHP) application.
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.
Issuer ID	The issuer’s 5-digit Health Insurance Oversight System (HIOS) ID.
Plan ID	The issuer’s 14-alpha-numeric ID.
Claims Payment Policies and Practices and Other Information URL	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 claims 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; explanation of benefits (EOB); and coordination of benefits (COB), as explained in Section V of the Supporting Statement and Appendix C.
Periodic Financial Disclosure*	URL link to National Association of Insurance Commissioners (NAIC) web page listing issuer premium receipts, assets, and liabilities in dollar amounts.
Data on Enrollment*	Issuer-level enrollment numbers as derived from the Federally-facilitated Exchange (CMS data).
Data on Disenrollment*	Issuer-level disenrollment numbers as derived from the Federally-facilitated Exchange (CMS data).
Issuer Level Claims Data	<p>Issuers will provide:</p> <ul style="list-style-type: none"> • In-network: <ul style="list-style-type: none"> ○ Claims received; ○ Claims resubmitted; and ○ Claims denied. • Out-of-network: <ul style="list-style-type: none"> ○ Claims received; ○ Claims resubmitted; and ○ Claims denied. • Appeals: <ul style="list-style-type: none"> ○ Internal appeals filed;

According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-1310 (Expires XX/XX/20XX). The time required to complete a one-time technical modification is estimated to average 11 hours per response for QHP issuers. The time required to complete an annual submission of Transparency in Coverage data is estimated to average 44 hours per response for QHP issuers. If you have comments concerning the accuracy of the time estimate(s) or suggestions for improving this form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Reports Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. ****CMS Disclosure**** Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact Jack Reeves at Jack.Reeves@cms.hhs.gov.

Data Element Name	Data Element Description
	<ul style="list-style-type: none"> ○ Internal appeals overturned; ○ External appeals filed; and ○ External appeals overturned.
Plan Level Claims Data	<p>Issuers will provide:</p> <ul style="list-style-type: none"> ● In-network: <ul style="list-style-type: none"> ○ Claims received; ○ Claims resubmitted; and ○ Claims denied. ● Out-of-network: <ul style="list-style-type: none"> ○ Claims received; ○ Claims resubmitted; and ○ Claims denied.
Plan Level Claim Denial Data	<p>Issuers will provide:</p> <ul style="list-style-type: none"> ● Claim denial reasons: <ul style="list-style-type: none"> ○ Enrollment status; ○ Benefit limit reached; ○ Investigational, cosmetic, or experimental procedure; ○ Prior authorization or referral required; ○ Exclusion of service; ○ Medical necessity, excluding behavioral health; ○ Medical necessity, behavioral health only; ○ Out of network provider/claims; ○ Administrative; and ○ Other.