Transparency in Coverage

1. Introduction

Issuers seeking certification of a QHP must make accurate and timely disclosures of transparency reporting[1] information to the appropriate Exchange, Secretary of HHS, state insurance commissioner, and make it available to the public[2]. These instructions apply to only FFM and SBM-FPs. There are no requirements for SBM issuers at this time.

2. Data Requirements

To complete this section, issuers will need the following:

- HIOS Issuer ID;
- Issuer Legal Name;
- Points of Contact;
- Claims Policy and URL;
- Number of Claims; and
- Number of Appeals.

3. Quick Reference

Key Changes for 2018
◆ No changes for 2018

Tips for the Transparency in Coverage
◆ Issuers that did not offer QHPs in 2016 must submit a Transparency in Coverage Template. The data elements that are required will be **identified by a caret (^)** next to the field name. If a field is not required, enter "N/A". ◆ Complete the template for each unique HIOS Issuer ID

4. Detailed Section Instructions

Perform the following steps to complete the Transparency in Coverage Template (Figure A3-1).

[1] Section 2715A of the PHS Act, extends the transparency reporting provisions under section 1311(e)(3) to non-grandfathered groups and issuers offering group or individual coverage, except for a plan not offered through an Exchange.

[2] The implementation of the transparency reporting requirements under 1311(e)(3) for QHP issuers as described in this document does not apply to non-Exchange coverage, including health insurance issuers offering group and individual health insurance coverage and non-grandfathered group health plans. Transparency reporting for those plans and issuers is set forth under 2715A of the PHS Act, incorporated into section 715(a)(1) of the Employee Retirement Income Security Act (ERISA) and section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

Figure A3-1. Transparency in Coverage Template

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting Plan Year 2018	
Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.	
General Information	
Was this plan on the Exchange in 2016?	
Issuer Name	
Issuer D/B/A, if Applicable	
Issuer HIOS ID	
Plan ID	
Issuer Point of Contact Name	
Issuer Point of Contact E-mail Address	
Issuer Point of Contact Phone Number	
Issuer Backup Point of Contact	
Issuer Backup Point of Contact E-mail Address	
Issuer Backup Point of Contact Phone Number	
2018 Data: Reporting of all fields is required for 2018	
Claims Payment Policies & Other Information URL	
Number of Claims Received in Calendar Year 2016 for Services Rendered in 2016	
Number of Claims Denied in Calendar Year 2016	
Number of Internal Appeals Filed in Calendar Year 2016	
Number of Internal Appeals Overturned from Calendar Year 2016 Appeals	
Number of External Appeals Filed in Calendar Year 2016	
Number of External Appeals Overturned from Calendar Year 2016 Appeals	
Notes: (Please enter any comments/notes here.)	

General Information	*Steps*
Issuer Name ^	Enter the issuer's legal name.
Issuer D/B/A, if Applicable ^	The issuer's marketing name, if different from the Issuer Name, above.
Issuer HIOS ID ^	Enter the five-digit HIOS Issuer ID.
Issuer Point of Contact Name ^	Enter the first and last name of the issuer's primary point of contact.
Issuer Point of Contact E-mail Address ^	Enter the e-mail address for the issuer's point of contact.
Issuer Point of Contact Phone Number ^	Enter the phone number for the issuer's point of contact.
Issuer Back-up Point of Contact ^	Enter the first and last name of the issuer's back-up point of contact.
Issuer Back-up Point of Contact E-mail Address ^	Enter the email address for the issuer's back-up point of contact.
Issuer Back-up Point of Contact Phone Number ^	Enter the phone number for the issuer's back-up point of contact.

2018 Data	Steps	
Claims Payment Policies & Other Information URL ^	Enter the URL (website). The URL is the web address on the issuer website that consumers use to view the providers claims information including:	
	Out-of-network liability and balance billing	**Description**: ◆ 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. **Provide**: ◆ 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. ◆ 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 claim submission	**Description**: ◆ An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received. **Provide**: ◆ 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.
	Grace periods and claims pending	**Description**: ◆ 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). **Provide**: ◆ 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.

2018 Data	Steps	
	Retroactive denials	**Description**: ◆ A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment. **Provide**: ◆ 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.
	Recoupment of overpayments	**Description**: ◆ Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer. **Provide**: ◆ Instructions to enrollees on obtaining a refund of premium overpayment.
	Medical necessity and prior authorization timeframes and enrollee responsibilities	**Description**: ◆ 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. **Provide**: ◆ 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 exception timeframes and enrollee responsibilities (not required for SADPs)	**Description**: ◆ 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). **Provide**: ◆ 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.

2018 Data	*Steps*	
	Explanation of benefits (EOB)	**Description**: ◆ 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 **Provide**: ◆ 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	**Description**: ◆ Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first. **Provide**: ◆ An explanation of what COB is (i.e., that other benefits can be coordinated with the current plan to establish payment of services).
Number of Claims Received in Calendar Year 2016	Enter the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of the network for an issuer (such as an HMO or PPO). Claims should be counted by date of service (DOS).	
Number of Claims Denied in Calendar Year 2016	Enter the number of claims received by an issuer asking for a payment or reimbursement by or on behalf of an in-network health care provider (such as a hospital or doctor) that is contracted to be part of the network for an issuer (such as an HMO or PPO) that the issuer subsequently denied. ◆ A claim means any individual line of service within a bill for services (medical and pharmacy, including pharmacy point of sale). ◆ Include claims for all QHPs in FFMs and SBM-FPs that fall under the reporting HIOS ID. If the issuer has more than one HIOS ID, it should submit a separate spreadsheet for each HIOS ID. ◆ Do not include claims that were pended for additional information and subsequently paid. ◆ Do not include out-of-network claims. ◆ Include <u>all</u> denials in the total number of claims denied in calendar year 2016. This includes, but is not limited to: ▪ Pediatric vision and dental denials; ▪ Partial denials; ▪ Denials due to ineligibility; ▪ Denials due to incorrect submission; ▪ Denials for incorrect billing; and ▪ Duplicate claims.	

2018 Data	*Steps*
Number of Internal Appeals Filed in Calendar Year 2016	Enter the number of requests by the insured for internal reviews of grievances involving adverse determinations. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or health care service for a covered person.
Number of Internal Appeals Overturned from Calendar Year 2016	Enter the number of final determinations adverse to the consumer that are overturned upon request for internal review, in whole or in part. An internal review is a process by which the insured may have an adverse determination reviewed by the issuer with respect to a denial of an admission, availability of care, continued stay, or health care service for a covered person.
Number of External Appeals Filed in Calendar Year 2016	Enter the number of requests by the insured for appeals on final adverse determinations to an external review organization.
Number of External Appeals Overturned from Calendar Year 2016	Enter the number of final adverse determinations overturned upon request for external review, in whole or in part.

Issuers are required to use the deadlines shown below for the transparency data submission.

Activity	Dates
Initial QHP transparency submission window	07/31/2017—09/01/2017
CMS reviews initial QHP data submissions as of 09/01/2017	09/04/2017—09/08/2017
CMS sends first correction/non-submission notice	09/11/2017—09/14/2017
Deadline for submission of revised QHP data	09/28/2017
CMS reviews revised QHP data as of 09/28/2017	09/28/2017—10/06/2017

Once the template is completed, issuers must save and submit their template to: Transparency@cms.hhs.gov. Issuers will receive an automated response indicating that the template has been received. Issuers who need to resubmit or correct any errors, must follow the steps above.

If issuers have questions about the transparency data submission process, contact the CMS Exchange Operations Support Center Help Desk at 855-CMS-1515 or via e-mail at CMS_FEPS@cms.hhs.gov.