

# Qualified Health Plan Issuer Application Instructions

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2020

**Extracted subsection:**  
**Appendix C. Transparency in Coverage Template**

05/2019

Version 1.1

## Appendix C. Transparency in Coverage Template

### 1. Introduction

This document provides instructions for QHP issuers submitting transparency in coverage data (transparency data) for PY2020.<sup>25</sup>

Issuers seeking certification of a QHP must make accurate and timely disclosures of transparency reporting<sup>26</sup> information to the appropriate Exchange, the Secretary of HHS, and the state insurance commissioner and make the information available to the public.<sup>27</sup> These instructions apply to issuers applying for QHP certification in FFEs in PY2020, including issuers in FFEs where states are performing plan management functions. This includes SADPs, SHOP QHPs, and Multi-State Plans. There are no requirements for SBE issuers at this time.

### 2. Data Requirements

To complete this section, issuers will need the following:

- Information on whether the QHP was on the Exchange in 2018;
- HIOS Issuer ID and Plan IDs;
- Issuer legal name;
- Points of contact;
- Claims payment and other policies and associated URL;
- Number of claims; and
- Number of appeals.

Issuers should only include data from on-Exchange QHPs. Transparency reporting requirements are only applicable for those QHP issuers applying for certification of a plan as a QHP in PY2020. Transparency in coverage reporting is not required for QHPs that will no longer be offered in PY2020. Issuers should provide PY2020 Issuer ID and Plan IDs in the reporting template. Issuers that have unique HIOS IDs in the same state must submit a Transparency in Coverage template for each unique HIOS ID.

Issuers must report on claims data for dates of service from January 1, 2018 to December 31, 2018. Issuers should only include 2018 data from on-Exchange plans that are participating on the Exchange in the 2020 plan year. For example, if a plan was offered on-Exchange in 2018, but will not be offered on-Exchange in PY2020, no transparency reporting data is required for that plan.

### 3. Quick Reference

Key Changes for 2020
Section 4.2 Plan Level Data Tab information is new for issuers.

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<sup>25</sup> OMB Control Number CMS-10572.

<sup>26</sup> 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.

<sup>27</sup> The implementation of the transparency reporting requirements under Section 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 and Section 9815(a)(1) of the Internal Revenue Code (Code) and will be addressed separately.

### Tips for the Transparency Template

- ◆ Issuers that seek to offer QHPs for PY2020 but did not offer QHPs in 2018 must still submit a Transparency in Coverage Template for 2018 data.
- ◆ The data elements that are required will be **identified by a caret (^)** next to the field name. If a field is not required and does not apply to your organization, enter “N/A.”
- ◆ Complete the template for each unique HIOS Issuer ID.
- ◆ **Use only the tabs provided in the Transparency Template and do not add additional tabs. Separate templates should be submitted for each unique HIOS Issuer ID.**
- ◆ **Enter all Plan Level data in the Plan Level Data tab. One Plan ID should be captured in each row.**
- ◆ Test the URL(s) to ensure proper function prior to submission.
- ◆ Once completed, submit the Transparency template using the following naming convention: “PY2020\_Transparency\_in\_Coverage\_Template\_[ISSUER ID]”.
- ◆ **Once the template is completed, issuers must save the template as an Excel file and submit their template to [Transparency@cms.hhs.gov](mailto:Transparency@cms.hhs.gov) by the required deadline.**

## 4. Transparency in Coverage Template

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

**Figure C-1. Transparency in Coverage Template**

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting Plan Year 2020	
OMB control number: 0938-1310/Expiration date: 04/22/2022	
Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.	
<b>General Information</b>	
Was this issuer on the Exchange in 2018?	
Issuer Name	
Issuer D/B/A, if Applicable	
Issuer HIOS 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	
<b>2020 Issuer Data: Reporting of all fields is required for 2020</b>	
Claims Payment Policies & Other Information URL	
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2018 That Were Also Received in Calendar Year 2018	
Number of Issuer Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	
Number of Issuer Level Internal Appeals Filed in Calendar Year 2018	
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2018 Appeals	
Number of Issuer Level External Appeals Filed in Calendar Year 2018	
Number of Issuer Level External Appeals Overturned from Calendar Year 2018 Appeals	
<b>Notes: (Please enter any comments/notes here.)</b>	

### 4.1 Issuer Level Data

General Information	Steps
Was this issuer on the Exchange in 2018? <sup>^</sup>	Enter Yes or No to indicate whether or not this issuer was on the Exchange in 2018. ◆ If Yes, the issuer must fill out claims and appeals data. ◆ If No, the issuer must enter “N/A” to the claims and appeals data fields.
Issuer Name <sup>^</sup>	Enter the issuer’s legal name.
Issuer D/B/A, if Applicable <sup>^</sup>	Enter the Issuer’s D/B/A. If not applicable, enter N/A.
Issuer HIOS ID <sup>^</sup>	Enter the five-digit HIOS Issuer ID. If the issuer has more than one HIOS ID, it should submit a separate template for each HIOS ID.
Issuer Point of Contact Name <sup>^</sup>	Enter the first and last name of the issuer’s primary point of contact for transparency data.

General Information	Steps
Issuer Point of Contact Email Address^	Enter the email 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 Email 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.

PY2020 Data	Steps	
Claims Payment Policies & Other Information URL <sup>^</sup>	Enter the active and easily accessible URL. A URL is easily accessible when: <ul style="list-style-type: none"><li>◆ It can be viewed on the plan's public website via a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and</li><li>◆ When an individual can easily discern which information applies to each plan the issuer offers.</li></ul> The URL is the web address on the issuer website that consumers use to view providers' claims information. All URLs should be live, with one URL for a landing page or a single page with a link providing the information indicated below. Issuers that have unique HIOS IDs in the same state may submit the same URL, if the Transparency in Coverage information is the same across the HIOS IDs.	
	Out-of-network liability and balance billing	<b>Description:</b> <ul style="list-style-type: none"><li>◆ 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.</li></ul> <b>Provide:</b> <ul style="list-style-type: none"><li>◆ Information regarding whether an enrollee may have financial liability for out-of-network services.</li><li>◆ Any exceptions to out-of-network liability, such as for emergency services.</li><li>◆ 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.</li></ul>
	Enrollee claim submission	<b>Description:</b> <ul style="list-style-type: none"><li>◆ An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.</li></ul> <b>Provide:</b> <ul style="list-style-type: none"><li>◆ General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim. If claims can only be submitted by a provider, this should be indicated as well.</li><li>◆ A time limit to submit a claim, if applicable.</li><li>◆ Links to any applicable forms.</li><li>◆ The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.</li></ul>
	Grace periods and claims pending	<b>Description:</b> <ul style="list-style-type: none"><li>◆ 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).</li></ul> <b>Provide:</b> <ul style="list-style-type: none"><li>◆ An explanation of what a grace period is.</li><li>◆ An explanation of what claims pending is.</li><li>◆ An explanation that the issuer 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.</li></ul>

PY2020 Data	Steps	
	Retroactive denials	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation that claims may be denied retroactively, even after the enrollee has obtained services from the provider, if applicable.</li> <li>◆ Ways to prevent retroactive denials when possible, for example paying premiums on time.</li> </ul>
	Recoupment of overpayments	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to over-billing by the issuer.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ Instructions to enrollees on obtaining a refund of premium overpayment.</li> </ul>
	Medical necessity and prior authorization time frames and enrollee responsibilities	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care.</li> <li>◆ Prior authorization is a process through which an issuer approves a request to access a covered benefit before the insured accesses the benefit.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation that some services may require prior authorization and may be subject to review for medical necessity.</li> <li>◆ Any ramifications should the enrollee not follow proper prior authorization procedures.</li> <li>◆ A time frame for the prior authorization requests.</li> </ul>
	Drug exception time frames and enrollee responsibilities (not required for SADPs)	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ 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).</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of the internal and external exceptions process for people to obtain non-formulary drugs.</li> <li>◆ The time frame for a decision based on a standard review or expedited review due to exigent circumstances.</li> <li>◆ Instructions on how to complete the application.</li> </ul>
	Explanation of benefits (EOB)	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ An EOB is a statement an issuer sends the enrollee to explain what medical treatments 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.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of what an EOB is.</li> <li>◆ Information regarding when an issuer sends EOBs (i.e., after it receives and adjudicates a claim or claims).</li> <li>◆ How a consumer should read and understand the EOB.</li> </ul>

PY2020 Data	Steps	
	Coordination of benefits	<p><b>Description:</b></p> <ul style="list-style-type: none"> <li>◆ Coordination of benefits exists when an enrollee is covered by more than one plan and determines which plan pays first.</li> </ul> <p><b>Provide:</b></p> <ul style="list-style-type: none"> <li>◆ An explanation of what coordination of benefits means (i.e., that other benefits can be coordinated with the current plan to establish payment of services).</li> </ul>
Number of Issuer Level Claims with Date(s) of Service (DOS) in 2018 That Were Also Received in Calendar Year 2018	<p>Enter the number of issuer level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an <b>in-network</b> healthcare 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). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value.</p> <ul style="list-style-type: none"> <li>◆ A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.</li> <li>◆ Include claims for all QHPs 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.</li> <li>◆ Do not include claims that were pended or denied for additional information and subsequently paid more than once.<sup>28</sup></li> <li>◆ Do not include out-of-network claims.</li> </ul>	
Number of Issuer Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	<p>Enter the number of issuer level claims received by an issuer that ask for a payment or reimbursement by or on behalf of an <b>in-network</b> healthcare 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) that the issuer subsequently denied.</p> <ul style="list-style-type: none"> <li>◆ A claim means any individual claim line of service within a bill for services (medical and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.</li> <li>◆ Include claims for all QHPs 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.</li> <li>◆ Do not include claims that were pended or denied for additional information and subsequently paid.</li> <li>◆ Do not include out-of-network claims.</li> <li>◆ Include <i>all</i> denials in the total number of claims denied in calendar year 2018. This includes, but is not limited to: <ul style="list-style-type: none"> <li>▪ Pediatric vision and dental denials, including SADPs;</li> <li>▪ Denials due to ineligibility;</li> <li>▪ Denials due to incorrect submission;</li> <li>▪ Denials for incorrect billing; and</li> <li>▪ Duplicate claims.</li> </ul> </li> </ul>	

<sup>28</sup> For example, if an issuer were to have a total of 10,000 claims:

- 8,000 paid immediately
- 1,000 pended or denied and resubmitted, of those,
  - 700 subsequently paid
  - 300 subsequently denied at some point in the plan year
- 1,000 denied immediately

The total number of claims to be reported is 10,000, and the total number of claims denied to be reported is 1,300 (1,000 immediate denials + 300 subsequently denied at some point in the plan year).

PY2020 Data	Steps
Number of Issuer Level Internal Appeals Filed in Calendar Year 2018	Enter the number of requests by the insured for internal appeals involving adverse determinations pursuant to 45 CFR §147.136. 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 payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer. Include appeals that the issuer received in 2018 for DOS in 2018 that were fully adjudicated/completed within 2018. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level Internal Appeals Overturned from Calendar Year 2018 Appeals	Enter the number of final determinations adverse to the insured that are overturned upon request for internal review, <b>in whole or in part</b> pursuant to 45 CFR §147.136. 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 payment, in whole or in part, for a service or treatment, or a rescission of coverage by the issuer.
Number of Issuer Level External Appeals Filed in Calendar Year 2018	Enter the number of requests by an insured for external appeals of final adverse determinations to an external review organization pursuant to 45 CFR §147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer. Include appeals that the issuer received in 2018 for DOS in 2018 that were fully adjudicated/completed within 2018. Do not include appeals that were subsequently withdrawn.
Number of Issuer Level External Appeals Overturned from Calendar Year 2018 Appeals	Enter the number of final adverse determinations overturned upon request for external review, <b>in whole or in part</b> pursuant to 45 CFR §147.136. An external appeal request is a process by which an insured may have an adverse benefit determination (or final internal adverse benefit determination) reviewed by an independent third-party reviewer.

**Figure C-2. Transparency in Coverage Template—Plan Level Tab**

Center for Medicare & Medicaid Services (CMS) Qualified Health Plan Transparency in Coverage Reporting Plan Year 2020 Please complete the fields below, following the instructions in the Transparency in Coverage QHP Issuer Instruction Guide.											
General Information			2020 Plan Data: Reporting of all fields is required for 2020								Notes
Issuer HIOS ID	2020 Plan ID	State	Number of Plan Level Claims with DOS in 2018 That Were Also Received in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to an Out-Of-Network Provider/Claims in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, <b>excluding</b> Behavioral Health in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, Behavioral Health <b>only</b> , in Calendar Year 2018	Number of Plan Level Claims with DOS in 2018 That Were Also Denied for "Other" Reasons in Calendar Year 2018	Notes: (Please enter any comments/notes here.)

Note: If the issuer was not on the Exchange in 2018, please mark N/A for the claims data fields.

## 4.2 Plan Level Data Tab

PY2020 Plan Data	Steps
Issuer HIOS ID <sup>^</sup>	Enter the five-digit HIOS Issuer ID on the Plan Level Data tab. If the issuer has more than one Plan ID to report, the HIOS Issuer ID should be repeated on each line.
2020 Plan ID <sup>^</sup>	Enter the 14-digit PY2020 Plan ID on the Plan Level Data tab. The Plan ID is composed of the five digit Issuer HIOS ID, the two character state abbreviation, and the seven digit unique digits for the plan. If there is more than one PY2020 Plan ID to report for a single HIOS Issuer ID, this information should be added line by line in the Plan Level Data tab.
State <sup>^</sup>	Enter the state abbreviation for this HIOS Issuer ID.



PY2020 Plan Data	Steps
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Received in Calendar Year 2018</p>	<p>Enter the number of in-network <b>plan level</b> claims received by an issuer that ask for a payment or reimbursement by or on behalf of a healthcare 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). Include pediatric dental and vision claims. Claims should be counted by date of service. Claims data must be reported with a single numerical value.</p> <ul style="list-style-type: none"> <li>◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.</li> <li>◆ Include claims for all QHPs that fall under the reporting Plan ID.</li> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6, should only be counted once.</li> <li>◆ Do not include out-of-network claims.</li> </ul>
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied in Calendar Year 2018 <b>(Plan Level Claims Denials)</b></p>	<p>Enter the number of <b>plan level</b> claims received by an issuer that ask for a payment or reimbursement by or on behalf of an in-network healthcare 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) that the issuer subsequently denied.</p> <ul style="list-style-type: none"> <li>◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment for services and benefits.</li> <li>◆ Include claims for all QHPs that fall under the reporting Plan ID.</li> <li>◆ Include all denials in the total number of claims denied in calendar year 2018. This includes, but is not limited to: <ul style="list-style-type: none"> <li>▪ Pediatric vision and dental denials, including for SADPs;</li> <li>▪ Denials due to ineligibility;</li> <li>▪ Denials due to incorrect submission;</li> <li>▪ Denials for incorrect billing; and</li> <li>▪ Duplicate claims.</li> </ul> </li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ Out-of-network claims.</li> </ul> <p><i>The total number of Plan Level Claims Denied in the specified calendar year should also be accounted for in the six "Plan Level Claims Denial" categories. Note, however, that the totals from the "Plan Level Claims Denial" categories will not add up to the total number of Plan Level Claims Denied.</i></p>

PY2020 Plan Data	Steps
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2018 <b>(Plan Level Claims Denial)</b></p>	<p>Enter the number of in-network <b>plan level</b> denials for non-emergency-related claims for service that required prior/pre-authorization, referral, prior approval, or precertification; in this instance the claim was denied for plans that require a prior/preauthorization, referral, prior approval, or precertification. <i>If the plan does not require prior approval for services, please enter N/A.</i></p> <p>Issuers should include the following claims (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ Total number of claims denied for services or supplies received after prior/pre-authorization, referral, prior approval, or pre-certification has been denied.</li> <li>◆ Total number of claims denied for services or supplies when an enrollee is required to receive prior/pre-authorization, referral, prior approval, or precertification, but fails to.</li> <li>◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.</li> <li>◆ Health services obtained without a referral when a referral is necessary.</li> <li>◆ Include claims for all QHPs that fall under the reporting Plan ID.</li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ Out-of-network claims.</li> </ul>
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to an Out-of-Network Provider/Claims in Calendar Year 2018 <b>(Plan Level Claims Denial)</b></p>	<p>Enter the number of <b>plan level</b> denial of claims for services from outside of the plan's network of healthcare providers when the plan has a closed network. <i>If the plan does not have a closed network, please enter N/A.</i></p> <p>Issuers should include the following claims (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ Total number of claims denied for point of service benefit provided by someone (example: healthcare provider, clinic, pharmacy, or hospital) that is not contracted to be in the plans (HMO or PPO) network.</li> <li>◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.</li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ In-network claims.</li> </ul>
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2018 <b>(Plan Level Claims Denial)</b></p>	<p>Enter the number of in-network <b>plan level</b> denial of claims for services excluded or non-covered services.</p> <p>Issuers should include (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ Total number of claims denied due to limitations or exclusions of certain services, test, treatment, admissions, supplies, etc., that are excluded, not covered, and/or limited under the plan, including claims denied as a result of a drug not being on the formulary.</li> <li>◆ A claim means any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale); a request for payment or reimbursement for services and benefits.</li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ Out-of-network claims.</li> </ul>

PY2020 Plan Data	Steps
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, <u>Excluding Behavioral Health</u> in Calendar Year 2018 <b>(Plan Level Claims Denial)</b></p>	<p>Enter the number of in-network <b>plan level</b> denial of claims for healthcare services or supplies that do not meet the accepted standards to diagnose or treat an illness, injury, condition, disease, or its symptoms related to medical services.</p> <p>Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales.</li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Behavioral or mental health claims or payment for services. <ul style="list-style-type: none"> <li>▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.</li> <li>▪ Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the Diagnostic and Statistical Manual of Mental Disorders (DSM), the most current version of the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.</li> <li>▪ Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD.</li> </ul> </li> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ Out-of-network claims.</li> </ul>
<p>Number of Plan Level Claims with DOS in 2018 That Were Also Denied Due to Lack of Medical Necessity, <u>Behavioral Health only</u>, in Calendar Year 2018 <b>(Plan Level Claims Denial)</b></p>	<p>Enter the number of in-network <b>plan level</b> denial of claims for healthcare services or supplies that do not meet the acceptable standards to diagnose or treat an illness, injury, condition, disease, or its symptoms, related to behavioral/mental health. Issuers should include the following claims denials for lack of medical necessity (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health. <ul style="list-style-type: none"> <li>▪ Behavioral health claims or payments are those benefits associated with mental health or substance use disorders.</li> <li>▪ Mental health claims or payments are those benefits associated with mental health conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD. Report claims as behavioral or mental health if the primary/principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM.</li> <li>▪ Substance use disorder claims or payments are those benefits associated with the treatment or diagnosis of substance use conditions; the classification of mental health claims should align with the current version of the DSM, the most current version of the ICD, federal, or state guidelines.</li> </ul> </li> </ul> <p>Do not include the following claims:</p> <ul style="list-style-type: none"> <li>◆ Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales.</li> <li>◆ Claims that were pending or initially denied for additional information and subsequently paid, as shown in <b>Footnote 28</b> on page C-6.</li> <li>◆ Out-of-network claims.</li> </ul> <p>Issuers may enter "N/A" in this field for SADPs.</p>

PY2020 Plan Data	Steps
Number of Plan Level Claims with DOS in 2018 That Were Also Denied for "Other" Reasons in Calendar Year 2018 <b>(Plan Level Claims Denial)</b>	<p>Enter the number of in-network <b>plan level</b> denial of claims rejected for a variety of reasons. Issuers should include (individual claim line of service item):</p> <ul style="list-style-type: none"> <li>◆ incorrect bill coding;</li> <li>◆ patient not insured by the plan;</li> <li>◆ coverage terminated;</li> <li>◆ duplicate claims;</li> <li>◆ coordination of benefits issues/failures;</li> <li>◆ untimely claims filings based on an issuers time frame for filing a claim;</li> <li>◆ denial because a procedure is considered experimental, cosmetic, or investigational;</li> <li>◆ <b>any other claim denied for any services not appropriate for the previous plan level categories.</b></li> </ul> <p>Do not include out-of-network claims.</p>

PY2020 Deadlines—Issuers are required to use the deadlines shown below for the transparency data submission.

Activity	Dates
Initial QHP transparency submission window	July 29, 2019–September 13, 2019
CMS reviews initial QHP data submissions as of September 13, 2019	September 16–20, 2019
CMS sends first correction/non-submission notice	September 23–25, 2019
Deadline for submission of revised QHP data	October 2, 2019
CMS reviews revised QHP data as of October 2, 2019	October 3–8, 2019

Please note: The PY2021 deadlines will align with the QHP submission process.

Once the template is completed, issuers must save the template as an Excel file and submit their template to [Transparency@cms.hhs.gov](mailto:Transparency@cms.hhs.gov) by the required deadline above. 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 for resubmission to correct any identified error(s).

Issuers may find the Transparency in Coverage URL Checklist (**Figure C-3**) to be a useful resource to ensure that all transparency data requirements are met. This document is not required for submission, but rather a useful guide to ensure issuers complete all sections of the template for each unique HIOS Issuer ID and test each URL to ensure proper functioning prior to the data submission.

If issuers have questions about the transparency data submission process, contact the CMS Marketplace Service Desk at 855-CMS-1515 or via email at [CMS\\_FEPS@cms.hhs.gov](mailto:CMS_FEPS@cms.hhs.gov).

Figure C-3. Transparency in Coverage URL Checklist

## Transparency in Coverage URL Checklist

### Introduction

This checklist is a resource for issuers who are submitting transparency in coverage data to ensure that all transparency data requirements have been met. Issuers must complete all sections of the template for each unique HIOS Issuer ID and test the URL (s) to ensure proper function prior to submission.

*Note: This document is not for submission*

### Checklist

#### URL

URL Information:

- ☐ URL is live upon Transparency submission.
- ☐ URL is accessible on the plan's public website without requiring an individual to create or access an account or enter a policy number.
- ☐ One URL for a single landing page.

#### Claims Payment Policies and Practices URL Data Display Elements:

Out-of-network liability and balance billing, includes the following:

- ☐ Information regarding whether an enrollee may have financial liability for out-of-network services.
- ☐ Information regarding any exceptions to out-of-network liability, such as for emergency services.
- ☐ Information regarding whether an enrollee may be balance-billed.

Enrollee claim submission, includes 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 download any applicable claim forms.
- ☐ A physical mailing address to mail claims documents

Grace periods and claims pending, includes 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, includes 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.

Recoupment of overpayments, includes the following:

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

Medical necessity and prior authorization timeframes and enrollee responsibilities, includes 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 a decision based on the prior authorization requests.

Drug exception timeframes and enrollee responsibilities (not required for SADPs), includes 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.

Explanation of benefits (EOB), includes 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, includes the following:

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