CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

QHP Certification
Health Insurance Marketplace

TRANSPARENCY IN COVERAGE

QHP Issuer Instruction Guide for Plan Year 2017

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Instructions for Submission of Qualified Health Plan (QHP) Transparency in Coverage Data for Plan Year 2017

This document provides instructions for qualified health plan (QHP) issuers submitting transparency in coverage data (transparency data). This document provides instructions for transparency in coverage data reporting for the 2017 plan year (PY).

1.0 Purpose of Collection

Under section 1311(e)(3) of the Affordable Care Act, as implemented by regulations at 45 CFR 155.1040(a) and 156.220, health insurance issuers seeking certification of a health plan as a qualified health plan (QHP) must make accurate and timely disclosures of certain information to the appropriate Health Insurance Marketplace[SM1] (also known as Exchange), the Secretary of HHS, and the state insurance commissioner, and make it available to the public. Section 2715A of the PHS Act, as added by the Affordable Care Act, extends the transparency reporting provisions under section 1311(e)(3) to non-grandfathered group health plans and health insurance issuers offering group or individual coverage, except that a plan or coverage not offered through an Exchange shall only be required to submit such information to the Secretary of HHS and state insurance commissioner, and make the information public.

2.0 Issuers Required to Submit Transparency Data[2]

QHP issuers in the Federally-facilitated Marketplaces (FFMs), including issuers in FFMs where states are performing plan management functions, and State-based Marketplaces on the Federal Platform (SBM-FPs) must submit transparency data. Based on the phased-in approach, there are no federal reporting requirements for issuers in SBMs at this time.

If the issuer has more than HIOS ID, it should submit a separate spreadsheet for each HIOS ID.

[1] Health Insurance Marketplace[SM] and Marketplace[SM] are service marks of the U.S. Department of Health & Human Services.

[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.

3.0 Data Elements Required for Submission

Issuers are required to submit the following data elements, as noted in the CMS Transparency in Coverage Reporting Template (Transparency Template), for plan year 2017. The data collection period for the 2017 plan year transparency data reporting is January 1, 2015 to December 31, 2015.

Table 3.1 provides details of the data elements to be submitted.

Year Reporting is Required	Data Element Name	Description
2017	Issuer Name	The legal name of the issuer.
2017	Issuer D/B/A, if Applicable	The issuer's marketing name, if different from the Issuer Name, above.
2017	Issuer HIOS ID	The issuer's Health Insurance Oversight System (HIOS) ID. If the issuer has more than one HIOS ID, it should submit a separate spreadsheet for each HIOS ID.
2017	Issuer Point of Contact Name	The first and last name of the issuer's primary point of contact for transparency data.
2017	Issuer Point of Contact E-mail Address	The e-mail address for the Issuer Point of Contact.
2017	Issuer Point of Contact Phone Number	The phone number for the Issuer Point of Contact.
2017	Issuer Backup Point of Contact	The first and last name of the issuer's backup point of contact for transparency data.
2017	Issuer Backup Point of Contact E-mail Address	The e-mail address for the Issuer Backup Point of Contact.
2017	Issuer Backup Point of Contact Phone Number	The phone number for the Issuer Backup Point of Contact.
2017	Claims Payment Policies & Other Information URL	Each issuer will submit a URL to a web page on its website that explains: a. Out-of-network liability and balance billing; b. Enrollee claim submission; c. Grace periods and claims pending; d. Retroactive denials; e. Recoupment of overpayments;

		f. Medical necessity and prior authorization timeframes and enrollee responsibilities; g. Drug exception timeframes and enrollee responsibilities; h. Explanation of benefits (EOBs); and i. Coordination of benefits (COB). More information is provided in section 3.1 of this document.
2017	Number of Claims Denied in Calendar Year 2015	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). • 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.
2017	Number of Internal Appeals Filed in Calendar Year 2015	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.
2017	Number of Internal Appeals Overturned from Calendar Year 2015 Appeals	Number of final determinations adverse to the consumer that are overturned upon request for internal review. 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.
2017	Number of External Appeals Filed in Calendar Year 2015	Number of requests by the insured for appeals on final adverse determinations to an external review organization.
2017	Number of External Appeals Overturned from Calendar Year 2015 Appeals	Number of final adverse determinations overturned upon request for external review.

3.1 Active URL

Issuers are required to provide information on the following in an active URL for PY 2017. A URL is easily accessible when:
(i) It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and
(ii) If an issuer offers more than one plan, when an individual can easily discern what information applies to which plan.

All URLS should be live, with one URL for a landing page or single page with a link providing the information indicated below:

a. Out-of-network liability and balance billing

Description of the data element:

- 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.

Issuers will provide the following:

- 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.

b. Enrollee claims submission

Description of the data element:

- An enrollee, instead of the provider, submits a claim to the issuer, requesting payment for services that have been received.

Issuers will provide 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 any applicable forms.
- The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number.

c. Grace periods and claims pending policies during the grace period

Description of the data element:

- 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).

Issuers will provide 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.

d. Retroactive denials

Description of the data element:

- A retroactive denial is the reversal of a previously paid claim, through which the enrollee then becomes responsible for payment.

Issuers will provide 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.

e. Enrollee recoupment of overpayments

Description of the data element:

- Enrollee recoupment of overpayments is the refund of a premium overpayment by the enrollee due to the over-billing by the issuer.

Issuers will provide the following:

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

f. Medical necessity and prior authorization timeframes and enrollee responsibilities

Description of the data element:

- 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.

Issuers will provide 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 the prior authorization requests.

g. Drug exceptions timeframes and enrollee responsibilities

Description of the data element:

- 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).

Issuers will provide 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.

h. Information on Explanations of Benefits (EOBs)

Description of the data element:

- 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.

Issuers will provide 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.

i. Coordination of benefits (COB)

Description of the data element:

- Coordination of benefits exists when an enrollee is also covered by another plan and determines which plan pays first.

Issuers will provide the following:

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

4.0 Data Submission Window

Issuers are required to use the deadlines in this document for transparency data submission.

Table 4.1 Key dates in the QHP Transparency data submission process.

Activity	Dates
Initial QHP Transparency Submission Window	08/01/2016-08/15/2016

Activity	Dates
CMS Reviews Initial QHP Data Submissions as of 08/15/2016	08/16/2016-08/30/2016
CMS Sends First Correction/Non-submission Notice	09/01/2016
Deadline for Submission of Revised QHP Data	09/15/2016
CMS Reviews Revised QHP Data as of 09/15/2016	09/16/2016-09/23/2016

5.0 Submitting the Data

1. Issuer instructions and Transparency Template is located on the QHP Certification website in Step 6: Certify & Offer Plans https://www.cms.gov/CCIIO/Programs-and-Initiatives/Health-Insurance-Marketplaces/qhp.html
2. Test the URL(s) described at 3.1 to ensure proper function prior to submission.
3. Complete the Transparency Template for each HIOS ID, providing the required information.
4. Save the file as an Excel file.
5. Submit the completed Transparency Template to: Transparency@cms.hhs.gov by the required deadline, noted above. Once you have submitted the template, you will receive an automated response indicating your data has been received.
6. Issuers requiring resubmission of any data elements should follow the previous steps for resubmission and correct any identified error(s).

6.0 Questions

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