

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).

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. This information collection is for the submission of data related to transparency in coverage by QHP issuers to HHS, the Exchange, and the state insurance commissioner, and also make the information available to the public in plain language. The time required to complete this information collection includes a one-time technical modification estimated to average 11 hours per response for QHP issuers and the time required to complete an annual submission of Transparency in Coverage data estimated to average 44 hours per response for QHP issuers, including the time to review instructions, search existing data resources, gather the data needed, to review and complete the information collection. Pursuant to 45 CFR 156.220, QHP issuers are required to make this information available to consumers and CMS. CMS requires QHP issuers to update transparency in coverage data annually. 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, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850 and email Carolyn Sabini at Carolyn.Sabini@cms.hhs.gov, Attention: Information Collections Clearance Officer.

Data Element Name	Data Element Description
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; ○ 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.