

Transparency in Coverage Reporting by Qualified Health Plan Issuers

Appendix C – Claims Payment Policies and Practices URL

URL Element Name	URL Element Description
Out-of-network liability and balance billing	<p>Description:</p> <ul style="list-style-type: none"> Balance billing occurs when an out-of-network provider bills an enrollee for charges other than copayments, coinsurance, or the amount remaining on a deductible. <p>Provide:</p> <ul style="list-style-type: none"> Information regarding whether a consumer may have financial liability for out-of-network services. Any exceptions to out-of-network liability, such as for emergency services or pursuant to the No Surprises Act. Information regarding whether a consumer may be balance billed. You do not need to include specific dollar amounts for out-of-network liability or balance billing.
Enrollee claim submission	<p>Description:</p> <ul style="list-style-type: none"> An enrollee submits a claim instead of the provider, requesting payment for services received. <p>Provide:</p> <ul style="list-style-type: none"> General information on how an enrollee can submit a claim in lieu of a provider if the provider fails to submit the claim or does not submit claims. If claims can only be submitted by a provider, indicate this here. A time limit to submit a claim, if applicable. Links to any applicable forms. All forms must be easily identifiable and publicly accessible. Describe how an enrollee can submit a claim if you do not require any forms. List any identifying information such as name, member number, and other information that an enrollee must include for successful claim submission. The physical mailing address and/or email address where an enrollee can submit a claim, and a customer service phone number

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.

URL Element Name	URL Element Description
Grace periods and claims pending	<p>Description:</p> <p>QHP issuers 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. Issuers must pay claims during the first month of a grace period, and may pend claims during the second and third months. At the initiation of an enrollee grace period, issuers must provide a notification of the change in status and an explanation of the 90-day grace period for enrollees with premium tax credits, that all appropriate claims will continue to be paid in the first month, and information regarding whether the issuer pends claims in the second and third months, pursuant to 45 CFR 156.270(d).</p> <p>Provide:</p> <ul style="list-style-type: none"> • An explanation of what a grace period is. • An explanation of what claims pending is. • An explanation that you will pay all appropriate claims for services rendered to the enrollee during the first month of the grace period. • An explanation that you may pend claims for services rendered to the enrollee in the second and third months of the grace period. • An explanation that you do not pend claims, if applicable.
Retroactive denials	<p>Description:</p> <ul style="list-style-type: none"> • A retroactive denial reverses a previously paid claim, making the enrollee responsible for payment. <p>Provide:</p> <ul style="list-style-type: none"> • 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, such as paying premiums on time.
Recoupment of overpayments	<p>Description:</p> <ul style="list-style-type: none"> • If an issuer overbills an enrollee for a premium, they may use recoupment of overpayments to obtain a refund. <p>Provide:</p> <ul style="list-style-type: none"> • Instructions on how enrollees can obtain a refund of premium overpayment, including a phone number or email address they should contact.

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Medical necessity and prior authorization timeframes and enrollee responsibilities	<p>Description:</p> <ul style="list-style-type: none"> • Medical necessity is used to describe care that is reasonable, necessary, and appropriate, based on evidence-based clinical standards of care. • Prior authorization is a process by which an issuer approves a request to access a covered benefit before the enrollee accesses the benefit. <p>Provide:</p> <ul style="list-style-type: none"> • An explanation that some services may require prior authorization and may be subject to review for medical necessity. • An explanation of any ramifications should the enrollee not follow proper prior authorization procedures. • A timeframe for the issuer to provide a response to the enrollee or provider's prior authorization request, including urgent requests as applicable.
Drug exception timeframes and enrollee responsibilities (not required for SADPs)	<p>Description:</p> <ul style="list-style-type: none"> • 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). <p>Provide:</p> <ul style="list-style-type: none"> • An explanation of the internal exceptions process for people to obtain non-formulary drugs. • An explanation of the external exceptions process for people to obtain non-formulary drugs through external review by an impartial, third-party reviewer, or Independent Review Organization (IRO). • Timeframes for decisions based on standard reviews and expedited reviews due to exigent circumstances. • Instructions on how to submit required information to start the exceptions process. This includes a request form link, address, phone number, or fax number for the enrollee to contact.
Explanation of benefits (EOB)	<p>Description:</p> <ul style="list-style-type: none"> • An EOB is a statement an issuer sends an enrollee that lists the medical treatments or services paid for on an enrollee's behalf, what was paid, and the enrollee's financial responsibility pursuant to the terms of the policy. <p>Provide:</p> <ul style="list-style-type: none"> • An explanation of what an EOB is. • Information regarding when an issuer sends EOBs (e.g., after it receives and adjudicates a claim or claims). • How a consumer should read and understand the EOB. • An example EOB for illustrative purposes.

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Coordination of benefits (COB)	<p data-bbox="540 241 699 275">Description:</p> <ul data-bbox="589 281 1437 352" style="list-style-type: none"> <li data-bbox="589 281 1437 352">• COB allows an enrollee who is covered by more than one plan to determine which plan pays first. <p data-bbox="540 369 651 403">Provide:</p> <ul data-bbox="589 409 1421 508" style="list-style-type: none"> <li data-bbox="589 409 1421 508">• An explanation of what COB means (i.e., that other benefits can be coordinated with the current plan to establish payment of services).