Transparency in Coverage Data

June 28, 2018

2018 Qualified Health Plan (QHP) Series

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES

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Agenda

- Session Guidelines
- Key Dates
- Transparency in Coverage Data
- Question & Answer (Q&A) Session
- Resources
- Closing Remarks

Session Guidelines

- This is a 60-minute session.
- This webinar will provide an opportunity for Center for Consumer Information and Insurance Oversight (CCIIO) PM Subject Matter Experts (SMEs) to discuss Transparency in Coverage Data.
- For questions regarding content, contact the Centers for Medicare & Medicaid Services (CMS) Help Desk by email at: CMS_FEPS@cms.hhs.gov or by phone at: (855) 267-1515.
- For questions regarding logistics and registration, contact the Registrar at: (800) 257-9520.

Key Dates for Plan Year (PY)18 Data Submission

Date	Category	Activity
March 15, 2018	URRT Deadline	PY 2018 Q3 Unified Rate Review Template Submission Deadline
April 11, 2018	DCRQ Submission	Deadline for submitting PY 2018 Data Change Requests for the April DCW (SHOP Q3 Rate Change Window)
Prior to May 16, 2018	Refresh Date	Approximate Refresh Date for the PY 2018 April DCW
June 15, 2018	URRT Deadline	PY 2018 Q4 Unified Rate Review Template Submission Deadline
July 11, 2018	DCRQ Submission	Deadline for submitting PY 2018 Data Change Requests for the July DCW (SHOP Q4 Rate Change Window)
Prior to August 16, 2018	Refresh Date	Approximate Refresh Date for the PY 2018 July DCW

Additional Webinar Sessions

All questions regarding Enrollment, External Data Gathering Environment (EDGE) Server or Federally-facilitated Small Business Health Options Program (FF-SHOP) can be addressed during the following webinar sessions:

Program Area	Day	Time (ET)
Enrollment	Mondays (Bi-Weekly)	12:00 p.m. – 1:00 p.m.
EDGE Server	Tuesdays	11:30 a.m. – 1:00 p.m.
FF-SHOP	Tuesdays (Monthly)	1:00 p.m. – 2:00 p.m.

Please register if you wish to participate, even if you have registered for a previous series. For registration and additional information on CMS' webinar series, please log in to https://www.REGTAP.info.

Announcements

Transparency in QHP Coverage PY 19

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This presentation provides instructions for QHP issuers submitting transparency in coverage data for PY 19.

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Purpose of Collection

- Under section 1311(e)(3) of the PPACA, as implemented by regulations at 45 CFR 155.1040(a) and 156.220, health insurance issuers seeking certification of a health plan as a QHP must make accurate and timely disclosures of certain information to the appropriate Exchange, Secretary of Health and Human Services (HHS), and state insurance commissioner; and make it available to the public.
- Section 2715A of the Public Health Service (PHS) Act, as added by the PPACA, 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.

Issuers Required to Submit Transparency Data

- QHP issuers in the Federally-facilitated Exchanges (FFEs), including issuers in FFEs where states are performing plan management functions, and State-based Exchanges on the Federal Platform (SBE-FPs) must submit transparency data for PY 19. This includes Stand-alone Dental Plans (SADPs).
- Based on the phased-in approach, there are no federal reporting requirements for issuers in SBEs at this time.
- Transparency reporting requirements are applicable to:
  - QHP issuers offering one or more QHPs in PY 19.
  - On-Exchange QHPs only.

Data Elements Required for Submission

- Issuers are required to submit the data elements included on the CMS Transparency in Coverage Reporting Template (Transparency Template) for PY 19.
- This data collection effort is specific to implementation of the reporting requirements under PPACA section 1311(e)(3) for QHP issuers and 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.

Data Elements Required for PY 19 Submission Template

Centers for Medicare & Medicaid Services (CMS) Qualified Health Plan (QHP) Transparency in Coverage Reporting	
Plan Year 2019	
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 2017?	
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	
2019 Data: Reporting of all fields is <u>required</u> for 2019	
Claims Payment Policies & Other Information URL	
Number of Claims Received in Calendar Year 2017 for Services Rendered in 2017	
Number of Claims Denied in Calendar Year 2017	
Number of Internal Appeals Filed in Calendar Year 2017	
Number of Internal Appeals Overturned from Calendar Year 2017 Appeals	
Number of External Appeals Filed in Calendar Year 2017	
Number of External Appeals Overturned from Calendar Year 2017 Appeals	
Notes: (Please enter any comments/notes here.)	

Data Elements Required for Submission for Issuers that did not offer QHPs in 2017

- Issuers that **did not** offer QHPs in 2017 must still submit a Transparency in Coverage Template.
- In the following slides, the data elements that are required for QHPs that **did not offer** QHPs in 2017 will be identified by a caret (^) next to the data element name. If a field is not required, enter “N/A.”

Data Elements Required for Submission for Issuers that did offer QHPs in 2017

- Issuers that **did offer** QHPs in 2017 must fill out all data elements on the Transparency Template.

Data Elements Required for Submission

Year Reporting is Required	Data Element Name	Description
2019	Was this plan on the Exchange in 2017? ^	Enter Yes or No, indicating whether or not this plan was on the Exchange in 2017.
2019	Issuer Name ^	The legal name of the issuer.
2019	Issuer D/B/A, if Applicable ^	The issuer's marketing name, if different from the Issuer Name, above.
2019	Issuer HIOS ID ^	The issuer's Health Insurance Oversight System (HIOS) ID. If the issuer has more than one (1) HIOS ID, the issuer should submit a separate spreadsheet for each HIOS ID.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Issuer Point of Contact Name ^	The first and last name of the issuer's primary point of contact for transparency data.
2019	Issuer Point of Contact E-mail Address ^	The e-mail address for the Issuer Point of Contact.
2019	Issuer Point of Contact Phone Number ^	The phone number for the Issuer Point of Contact.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Issuer Backup Point of Contact ^	The first and last name of the issuer's backup point of contact for transparency data.
2019	Issuer Backup Point of Contact E-mail Address ^	The e-mail address for the Issuer Backup Point of Contact.
2019	Issuer Backup Point of Contact Phone Number ^	The phone number for the Issuer Backup Point of Contact.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit an active and easily accessible URL (website). A URL is easily accessible when: (1) It can be viewed on the plan's public website through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and (2) If an issuer offers more than one plan, when an individual can easily discern what information applies to which plan. The URL is the web address on the issuer website that consumers use to view the providers claims information. 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; b. Enrollee claim submission; c. Grace periods and claims pending; d. Retroactive denials; e. Enrollee 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). ***If an issuer WAS NOT on the Exchange in 2017, no further information is required after the URL.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	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** **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **b. Enrollee claim 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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **c. Grace periods and claims pending** **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **g. Drug exception 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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Claims Payment Policies & Other Information URL ^	Each issuer will submit a URL to a web page on its website that explains: **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).

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Number of claims received in 2017	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 Health Maintenance Organization [HMO] or Preferred Provider Organizations [PPO]). Claims should be counted by date of service (DOS).

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Number of Claims Denied in Calendar Year 2017	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 FFEs and SBE-FPs that fall under the reporting HIOS ID. If the issuer has more than one HIOS ID, the issuer 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 all denials in the total number of claims denied in calendar year 2017. This includes, but is not limited to: o Pediatric vision and dental denials; o Partial denials; o Denials due to ineligibility; o Denials due to incorrect submission; o Denials for incorrect billing; and o Duplicate claims.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Number of Internal Appeals Filed in Calendar Year 2017	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.
2019	Number of Internal Appeals Overturned from Calendar Year 2017 Appeals	Number of final adverse determinations 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.

Data Elements Required for Submission (Continued)

Year Reporting is Required	Data Element Name	Description
2019	Number of External Appeals Filed in Calendar Year 2017	Number of requests by the insured for appeals on final adverse determinations to an external review organization.
2019	Number of External Appeals Overturned from Calendar Year 2017 Appeals	Number of final adverse determinations overturned upon request for external review.

Data Submission Window

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

Activity	Dates
Initial QHP Transparency Submission Window	07/31/2018-08/30/2018
CMS Reviews Initial QHP Data Submissions as of 09/05/2018	08/31/2018-09/05/2018
CMS Sends First Correction/Non-submission Notice	09/06/2018-09/10/2018
Deadline for Submission of Revised QHP Data	09/24/2018
CMS Reviews Revised QHP Data as of 09/24/2018	09/24/2018-10/01/2018

Submitting the Data

1. Test all URL(s) to ensure proper function prior to submission.
2. Complete the Transparency Template **for each HIOS ID**, providing the required information.
3. Save the file as an Excel file.
4. Submit the completed Transparency Template to: Transparency@cms.hhs.gov by the required deadline, noted on the earlier slide. Once you have submitted the template, you will receive an automated response indicating your data has been received.
5. Issuers requiring resubmission of any data elements should follow the previous steps for resubmission and correct any identified error(s).

Open Q&A Session

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Questions?

- To submit or withdraw questions by phone:
  - *To submit a question, dial "star(*) pound(#)" on your phone's keypad.*
  - *To withdraw a question, dial "star(*) pound(#)" on your phone's keypad.*
- To submit questions by webinar:
  - *Type your question in the text box under the "Q&A" tab and click "Send."*

Submission of Inquiries

Users/Issuers can contact:

- **CMS Help Desk** with questions about specific situations, the Federal Templates and their functionality and Health Insurance Oversight System (HIOS)
  - **Call: 855-CMS-1515**
  - **Email:** CMS_FEPS@cms.hhs.gov
- **National Association of Insurance Commissioners (NAIC)** with questions about state requirements/SERFF
  - **Email:** serffplanmgmt@naic.org

Best Practices- Submitting Help Desk Tickets

- Include HIOS ID, issuer state and issuer legal name.
- Include screenshots or attach templates when asking about an error or issue with the template.
- Submit separate Help Desk requests for different, unrelated questions.
- Put the question in the body of the email; do not attach Excel or Word documents with lists of questions.
- Identify or note whether a question is for the SHOP or Individual Exchange.

HIOS User Group Conference Call

- HIOS User Group Conference Call occurs every Wednesday from 2:00 p.m. to 3:30 p.m. Eastern Time (US & Canada) (GMT-05:00)
- Call Access: 1-888-455-8828; Passcode: 6714482

Plan Management Webinar Dates

The July QHP Webinar sessions occur on Thursdays as shown below:

Date	Day	Time (ET)	Topic
07/12/18	Thursday	1:00 p.m. – 2:00 p.m.	PM Community Series: In-Depth Training
07/19/18	Thursday	1:00 p.m. – 2:00 p.m.	PY19 Plan ID Crosswalk Template for Automatic Re-Enrollment – Refresher
07/26/18	Thursday	1:00 p.m. – 2:00 p.m.	JavaScript Object Notation (JSON) Validator Overview

Resources for QHP Plan Maintenance and Certification

Resource	Resource Link
CMS Regulations and Guidance	https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/index.html
Qualified Health Plan (QHP) Application Materials	https://www.qhpcertification.cms.gov/s/Application%20Materials
QHP Application Review Tools	https://www.qhpcertification.cms.gov/s/Review%20Tools
Registration for Technical Assistance Portal (REGTAP)	https://REGTAP.info
Health Insurance Oversight System (HIOS)	https://portal.cms.gov/wps/portal/unauthportal/home/
System for Electronic Rate and Form Filing (SERFF)	https://login.serff.com/

Commonly Used Acronyms

Acronym	Definition
AV	Actuarial Value
BHP	Basic Health Program
ECP	Essential Community Provider
EHB	Essential Health Benefit
EIDM	Enterprise Identity Management
FFE	Federally-facilitated Exchange
HIOS	Health Insurance Oversight System

Commonly Used Acronyms (Continued)

Acronym	Definition
MSP	Multi-State Plans
NAIC	National Association of Insurance Commissioners
NCQA	National Committee for Quality Assurance
QHP	Qualified Health Plan
SBE	State-based Exchange
SERFF	System for Electronic Rate and Form Filing
USP	United States Pharmacopeia

Closing Remarks