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Plan Level Claims Data	Note: Report all reasons a claim is denied. A claim can be denied for more than one reason. Therefore, the sum of the reasons why claims were denied may either be equal to or greater than the Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020.		
1. Number of **Plan Level** Claims with DOS in 2020 That Were Also **Received** in Calendar Year 2020	Enter the number of **in-network plan level** claims you received that ask for a payment or reimbursement by or on behalf of a health care provider (such as a hospital, physician, or pharmacy) that is contracted to be part of your network (such as an HMO or PPO). Include pediatric dental and vision claims. Count claims by date of service and report claims data with a single numerical value. <u>If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable</u> • A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). • Include claims for all QHPs that fall under the reporting plan ID. • Claims that were pending or initially denied for additional information and subsequently paid for any reason, should only be counted once. For example, the following each count as one claim: o An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. The enrollee appeals the denial and the denial is overturned. The issuer then approves the claim and pays for the service. o An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. Do not include out-of-network claims. The total issuer-level claims received data may include plans not offered in 2022. Therefore, the plan-level claims total may not total the issuer-level claims.	18126CA0010001	130671
		18126CA0010002	134234
		18126CA0010003	490739
		18126CA0010004	76922
		18126CA0010005	482
2. Number of **Plan Level** Claims with DOS in 2020 That Were Also **Denied** in Calendar Year 2020 (Plan Level Claims Denials)	Enter the number of **<u>plan level</u>** claims you received that asked for a payment or reimbursement by or on behalf of an **<u>in-network</u>** 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 HMO or PPO) that you subsequently denied**..** • A claim is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). • Include claims for all QHPs that fall under the reporting plan ID. • Count denied claims based on their final adjudication. For example, each of the following counts as one denied claim: o An issuer denies a claim for lack of sufficient information to process the claim. The provider then submits sufficient information, and the issuer denies the claim for lack of medical necessity. o An issuer denies a claim for being an excluded service. The claim is then resubmitted and denied again for the same reason. The enrollee appeals the decision but fails to overturn the denial. • Count a claim that was denied for more than one reason as one denied claim (e.g., no prior authorization received and not a covered service). Do not count each denial reason separately. • Include <u>all</u> denials in the total number of claims denied in calendar year 2020, including: o Pediatric vision and dental denials, including SADPs o Denials because of ineligibility	18126CA0010001	48390
		18126CA0010002	57612
		18126CA0010003	200154
		18126CA0010004	33530
		18126CA0010005	219

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	○ Denials caused by incorrect submission ○ Denials caused by incorrect billing ○ Duplicate claims. • Do not include out-of-network claims. 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 that CMS expects the sum of the six Plan Level Claims Denial categories to be greater than or equal to the Number of Plan Level Claims with DOS in 2020 That Were Also Denied in Calendar Year 2020 because individual claims may be denied for more than one reason.)	
3. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to **Prior Authorization or Referral Required** in Calendar Year 2020 **(Plan Level Claims Denied)**	NOTE: The following claim denial reporting for the plan-level tab are as detailed in the QHP Issuer Application Instructions 2022; Extracted section: Section 2E: Transparency in Coverage and differ from the instructions for issuer-level claim denial. Rather than reporting denied claims based on their final adjudication, report each incidence of the following denials that occur throughout the life of a claim. For example: • For the Issuer-Level tab and Column C of the plan-level tab: ○ If a claim is denied for any reason, then resubmitted and denied again without further resubmission, it will count as one denied claim. • For Columns D, E, F, G, H, and I: ○ If a claim is denied for lacking a prior authorization and being an excluded service, then resubmitted and denied again for lacking a prior authorization and being an excluded service, it will count twice in Column D (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Prior Authorization or Referral Required in Calendar Year 2020), and twice in Column F (Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to Exclusion of a Service in Calendar Year 2020). Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section, enter the number of in-network plan-level denials you issued for nonemergency-related claims for service that required prior authorization, preauthorization, referral, prior approval, or precertification; in this instance, the claim was denied for plans that require a prior or preauthorization, referral, prior approval, or precertification beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service items): • Total number of claims denied for services or supplies received after prior or preauthorization, referral, prior approval, or pre-certification was denied. • Total number of claims denied for services or supplies received when a consumer failed to obtain a required prior or preauthorization, referral, prior approval, or precertification. • A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). • Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example: ○ If a claim is denied for requiring a prior authorization, resubmitted, and denied again for the same reason, it will count as two denials in this category.	18126CA0010001 7535 18126CA0010002 10846 18126CA0010003 29714 18126CA0010004 3970 18126CA0010005 25

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	○ If a claim is denied for requiring a prior authorization, resubmitted with the required documentation, and paid, it will count as one denial in this category. Include claims for all QHPs that fall under the reporting plan ID. Do not include out-of-network claims.		
4. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to an **Out-of-Network** Provider/Claims in Calendar Year 2020 **(Plan Level Claims Denied)**	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section enter the number of **plan-level** denials you issued for claims for service from outside the plan's network of health care providers if the plan has a closed network beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. • Issuers should include the following claims (individual claim line of service item): ○ Total number of claims denied for point of service benefit provided by someone (e.g., health care provider, clinic, pharmacy, or hospital) that is not contracted to be in the plan's (HMO or closed network plans) network. ○ A claim is any individual claim line of service in a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). • Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example: ○ If a claim is denied for services from an out-of-network provider, resubmitted, and denied again for the same reason, it will count as two denials in this category. ○ If a claim is denied for services from an out-of-network provider, resubmitted with updated documentation, and paid, it will count as one denial in this category. • Do not include in-network claims.	18126CA0010001	6051
		18126CA0010002	6251
		18126CA0010003	16533
		18126CA0010004	3211
		18126CA0010005	48
5. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to **Exclusion of a Service** in Calendar Year 2020 **(Plan Level Claims Denied)**	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section enter the number of in-network **plan-level** denials you issued for claims for excluded or non-covered services. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service item): • Total number of claims denied because certain services, test, treatments, admissions, supplies, etc., are excluded, not covered, or limited under the plan, including claims denied as a result of a drug not being on the formulary. • A claim is any individual claim line of service within a bill for services (medical, behavioral health, and pharmacy, including pharmacy point of sale) or a request for payment or reimbursement for services and benefits (e.g., a bill containing 10 lines of services will be counted as 10 claims). • Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example: ○ If a claim is denied as an excluded service, resubmitted, and denied again for the same reason, it will count as two denials in this category. ○ If a claim is denied as an excluded service, resubmitted with updated documentation, and paid, it will count as one denial in this category.	18126CA0010001	14462
		18126CA0010002	19091
		18126CA0010003	65962
		18126CA0010004	8828
		18126CA0010005	42

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6. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to **Lack of Medical Necessity**, **Excluding Behavioral Health** in Calendar Year 2020 **(Plan Level Claims Denied)**	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section enter the number of in-network **plan-level** denials you issued for claims for health care services or supplies that do not meet accepted standards to diagnose or treat illness, injury, condition, disease, or the symptoms of these. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Include the following denials for lack of medical necessity (individual claim line of service item): o Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. o Use the following United States Pharmacopeia (USP) drug categories to count pharmacy claims excluding behavioral health: ▪ Analgesics ▪ Anesthetics ▪ Antibacterials ▪ Anticonvulsants ▪ Antidementia Agents ▪ Antiemetics ▪ Antifungals ▪ Antigout ▪ Antimigraine Agents ▪ Antimyasthenic Agents ▪ Antimycobacterials ▪ Antineoplastics ▪ Antiparasitics ▪ Antiparkinson Agents ▪ Antipasticity Agents ▪ Antivirals ▪ Blood Glucose Regulators ▪ Blood Products/Modifiers ▪ Cardiovascular Agents ▪ Central Nervous System Agents ▪ Dental and Oral Agents ▪ Dermatological Agents ▪ Electrolytes/Minerals/Metals/Vitamins ▪ Gastrointestinal Agents ▪ Genetic, or Enzyme, or Protein Disorder: Replacement, Modifiers, Treatment ▪ Genitourinary Agents ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Adrenal) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Pituitary) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Prostaglandins) ▪ Hormonal Agents, Stimulant/Replacement/Modifying (Sex Hormone/Modifiers)	18126CA0010001 649 18126CA0010002 930 18126CA0010003 2604 18126CA0010004 220 18126CA0010005 0

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	▪ Hormonal Agents, Stimulant/Replacement/Modifying (Thyroid) ▪ Hormonal Agents, Suppressant (Adrenal) ▪ Hormonal Agents, Suppressant (Pituitary) ▪ Hormonal Agents, Suppressant (Thyroid) ▪ Immunological Agents ▪ Infertility Agents ▪ Inflammatory Bowel Disease Agents ▪ Metabolic Bone Disease Agents ▪ Ophthalmic Agents ▪ Otic Agents ▪ Respiratory Tract/Pulmonary Agents ▪ Skeletal Muscle Relaxants ▪ Sleep Disorder Agents. • Do not include the following claims: o Behavioral or mental health claims or payment for services. ▪ Behavioral health claims or payments for benefits associated with mental health or substance use disorders. ▪ Mental health claims or payments for benefits associated with mental health conditions; as classified in the current versions of the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD). Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. ▪ Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and the ICD. o Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example: ▪ If a claim is denied due to lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. ▪ If a claim is denied due to lacking medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category.	
7. Number of Plan Level Claims with DOS in 2020 That Were Also Denied Due to **Lack of Medical Necessity,**	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section enter the number of in-network **plan-level** denials you issued for claims for health care services or supplies that do not meet the acceptable standards to diagnose or treat an illness, injury, condition disease, or the symptoms of these related to behavioral or mental health beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans must enter a value in this field; 0 is acceptable. If you responded Yes to SADP Only on the Issuer Level Data tab, no action is required.	18126CA0010001: 53 18126CA0010002: 182 18126CA0010003: 61 18126CA0010004: 2 18126CA0010005: 0

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Behavioral Health only, in Calendar Year 2020 **(Plan Level Claims Denied)**	• Issuers should include the following claims denials for lack of medical necessity (individual claim line of service items): Behavioral or mental health claims or payment for services, including pharmacy claims and pharmacy point of sales related to behavioral health. o Behavioral health claims or payments for benefits associated with mental health or substance use disorders. o 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 and the most current version of the ICD. Report claims as behavioral or mental health if the primary or principal diagnosis code reported is classified as behavioral or mental health according to the current version of the DSM. o Substance use disorder claims or payments for benefits associated with the treatment or diagnosis of substance use conditions as classified in the current versions of the DSM and ICD as well as federal or state guidelines. • Issuers should use the following USP drug categories to count pharmacy claims including behavioral health: o Anti-addiction/substance abuse treatment agents o Antidepressants o Antipsychotics o Anxiolytics o Bipolar agents. • Include all instances of this type of denial throughout the life of a claim in the total reported for this column. For example: o If a claim is denied for lacking medical necessity, resubmitted, and denied again for the same reason, it will count as two denials in this category. o If a claim is denied due to lack of medical necessity, resubmitted with updated documentation, and paid, it will count as one denial in this category. • Do not include the following claims: o Payment for services related to medical surgical diagnosis including medical, pharmacy, and pharmacy point of sales. o Out-of-network claims.	
8. Number of Plan Level Claims with DOS in 2020 That Were Also **Denied for "Other" Reasons** in Calendar Year 2020	Issuers may deny claims multiple times for multiple reasons throughout the life of a claim. For this section enter the number of in-network **plan** level denials you issued for claims rejected for reasons other than those specified above beginning from when a claim was first received to its final adjudication. If a plan did not exist in PY2020, enter N/A. All other on-Exchange plans (including SADPs) must enter a value in this field; 0 is acceptable. Issuers should include the following claims (individual claim line of service item): • Incorrect bill coding; • Patient not insured by the plan; • Coverage terminated; • Duplicate claims; • Coordination of benefits issues/failures;	18126CA0010001 29559 18126CA0010002 32530 18126CA0010003 117172 18126CA0010004 22354 18126CA0010005 168

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(Plan Level Claims Denied)	• Untimely claims filings based on an issuers time frame for filing a claim;
	• Denial because a procedure is considered experimental, cosmetic, or investigational;
	• Any other claim denied for any services not appropriate for the previous plan level categories.
	• Include all instances of a denial that falls in the "other" category throughout the life of a claim in the total reported for this column. For example:
	  o If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted, and denied again for the same reasons, it will count as four denials in this category.
	  o If a claim is denied for an incorrect billing code and a coordination of benefits issue, resubmitted with updated documentation, and paid, it will count as two denials in this category
	• Do not include out-of-network claims.	