The Center for Consumer Information & Insurance Oversight (CCIIO) Transparency in Qualified Health Plan (QHP) coverage Public Use File (PUF) Data Dictionary

CMS Center for Consumer Information & Insurance Oversight (CCIIO), Health Insurance Marketplace℠[1] Public Use Files (Marketplace PUFs) Data Dictionary for 2017 Transparency in QHP Coverage PUF with Data Collected January 1, 2015-December 31, 2015

1. Overview of the Transparency in QHP Coverage PUF

The Centers for Medicare & Medicaid Services (CMS) Center for Consumer Information & Insurance Oversight (CCIIO) is releasing this Transparency in Qualified Health Plan (QHP) Coverage Public Use File (PUF) in order to increase access to QHP issuer data reported pursuant to section 1311(e)(3) of the Affordable Care Act. The Transparency in QHP Coverage PUF includes data on QHPs and Stand-alone Dental Plans (SADPs) offered in states with Federally-Facilitated Marketplaces (FFMs), including issuers in the FFMs where states performing plan management functions, and State-based Marketplaces on the Federal Platform (SBM-FPs).[2]

The data dictionary describes the variables contained in the 2017 Transparency in QHP Coverage PUF. Each record relates to the coverage at the issuer level. The 2017 Transparency PUF reflects data from plan year 2015.

2. Variable Attributes

Variable Name:	State
Variable Definition:	Two-character state abbreviation indicating the state where the issuer offers coverage on the Marketplace
Data Type:	Text
Variable Label:	State Code
Allowable Values:	All 50 state abbreviations
Data Source:	System-generated field
Field Name from Data Source:	State Code

[1] Health Insurance Marketplace℠ and Marketplace℠ 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.

Comments:	N/A
Variable Name:	Issuer Name
Variable Definition:	Name of the company issuing the plan
Data Type:	Text
Variable Label:	Issuer Name
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A
Variable Name:	Issuer ID
Variable Definition:	Five-digit numeric code that identifies the issuer organization in the Health Insurance Oversight System (HIOS)
Data Type:	Text
Variable Label:	Issuer ID
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A
Variable Name:	Issuer D/B/A if Applicable
Variable Definition:	Issuer marketing name, if different from Issuer_Name
Data Type:	Text
Variable Label:	Issuer D/B/A, if Applicable
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	N/A
Variable Name:	URL Claims Payment Policies & other Information
Variable Definition:	URL link to policies on issuer websites
Data Type:	Text
Variable Label:	URL_Claims_Payment_Policies
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Record relates to coverage at the issuer level.
Variable Name:	Number of Claims Received in Calendar Year 2015
Variable Definition:	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 HMO or PPO). Claims are counted by date of service (DOS).

Data Type:	Text
Variable Label:	Number of Claims Received in Calendar Year 2015
Allowable Values:	Free text
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.

Variable Name:	Number of Claims Denials

Variable Definition:	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. Data is measured January 1, 2015-December 31, 2015.
	• 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 FFMs and SBM-FPs that fall under the reported HIOS ID. If the Issuer has more than HIOS ID, it should submit a separate spreadsheet for each HIOS ID.
	• Does not include claims that were pended for additional information and subsequently paid.
	• Does not include out-of-network claims.
	• Includes all denials in the total number of claims denied in calendar year 2015. This includes, but not limited to:
	  ○ Pediatric vision and dental denials;
	  ○ Partial denials;
	  ○ Denials due to ineligibility;
	  ○ Denials due to incorrect submission;
	  ○ Denials for incorrect billing; and
	  ○ Duplicate claims.

Data Type:	Text
Variable Label:	Claims_Denials
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Number of Internal Appeals Filed

Variable Definition:	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. Data is measured January 1, 2015- December 31, 2015.
Data Type:	Text
Variable Label:	Internal_Appeals_Filled
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the state level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Number of Internal Appeals Overturned
Variable Definition:	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. All overturned internal appeals must be included, including those overturned in whole or in part. Data is measured January 1, 2015- December 31, 2015.
Data Type:	Text
Variable Label:	Number_of_Internal_Appeals_Overturned
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2016- December 31, 2015.
Variable Name:	Percent of Internal Appeals Overturned
Variable Definition:	Percentage of adverse benefit determinations Overturned (# internal appeals overturned/# of internal appeals filed) by plan/issuer in favor of the beneficiary. Data is measured January 1, 2015- December 31, 2015.
Data Type:	Text
Variable Label:	Percent_of_Internal_Appeals_Overturned
Allowable Values:	Numbers
Data Source:	Issuer

Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Number of External Appeals Filed
Variable Definition:	Number of requests by the insured for appeals on final adverse determinations to an external review organization. Data is measured January 1, 2015-December 31, 2015.
Data Type:	Text
Variable Label:	External_Appeals_Filed
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Number of External Appeals Overturned
Variable Definition:	Number of final adverse determinations overturned upon request for external review, in whole or in part. Data is measured January 1, 2015-December 31, 2015.
Data Type:	Text
Variable Label:	Number_of_external_appeals_overturned
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Percent of External Appeals Overturned
Variable Definition:	Percent of final adverse determinations overturned (# external appeals overturned/# of external appeals filed) upon request for external review. Data is measured January 1, 2015-December 31, 2015.
Data Type:	Text
Variable Label:	Percent_of_external_appeals_overturned
Allowable Values:	Numbers
Data Source:	Issuer
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.
Variable Name:	Financial Information
Variable Definition:	URL link to prior calendar year issuer-level information

	about premiums, assets, and liabilities.
Data Type:	Text
Variable Label:	Financial_Information
Allowable Values:	Free text
Data Source:	National Association of Insurance Commissioners
Field Name from Data Source:	N/A
Comments:	Record relates to coverage at the issuer level. The information provided in the URL link reflects financial information that is current as of the date of initial publication of the PUF.
Variable Name:	Enrollment Data
Variable Definition:	Issuer level cumulative enrollment numbers, as measured by non-cancelled plan selections, based on the end of the prior calendar year's information. Data is measurement period is January 1st 2015 to December 31, 2015.
Data Type:	Text
Variable Label:	Enrollment_Data
Allowable Values:	Free text
Data Source:	CMS
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured from January 1, 2015-December 31, 2015.
Variable Name:	Disenrollment Data
Variable Definition:	Issuer level cumulative disenrollment numbers, as measured by cancelled plan selections, based on the end of the prior calendar year's information. Data measurement period is January 1, 2015-December 31, 2015.
Data Type:	Text
Variable Label:	Disenrollment_Data
Allowable Values:	Free text
Data Source:	CMS
Field Name from Data Source:	N/A
Comments:	Issuer-level data at the State level, for all QHPs on Marketplace. Data is measured January 1, 2015-December 31, 2015.