§ 156.1120 Quality rating system.

(a) Data submission requirement. (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year.

(2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS.

(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level specified by HHS.

(b) Timeline. A QHP issuer must annually submit data necessary to calculate the QHP’s quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS.

(c) Marketing requirement. A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS.

(d) Multi-State plans. Issuers of multi-State plans, as defined in §155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel Management, in the time and manner specified by the U.S. Office of Personnel Management.

[79 FR 30352, May 27, 2014]

Subpart M—Qualified Health Plan Issuer Responsibilities

SOURCE: 78 FR 54143, Aug. 30, 2013, unless otherwise noted.

§ 156.1210 Confirmation of HHS payment and collections reports.

(a) Responses to reports. Within 15 calendar days of the date of a payment and collections report from HHS, the issuer must, in a format specified by HHS, either:

(1) Confirm to HHS that the amounts identified in the payment and collections report for the timeframe specified in the report accurately reflect applicable payments owed by the issuer to the Federal government and the payments owed to the issuer by the Federal government; or

(2) Describe to HHS any inaccuracy it identifies in the payment and collections report.

(b) Late discovery of a discrepancy. If an issuer reports a discrepancy in a payment and collections report later than 15 calendar days after the date of the report, HHS will work with the issuer to resolve the discrepancy as soon as the late reporting was not due to misconduct on the part of the issuer.