issuer must authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf.

(b) *Data requirement.* (1) A QHP issuer must collect data for each QHP, with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year and following a survey sampling methodology provided by HHS.

(2) In order to ensure the integrity of the data required to conduct the survey, a QHP issuer must submit data that has been validated in a form and manner specified by HHS, and submit this data to its contracted ESS vendor.

(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the level 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) *Timeline.* A QHP issuer must annually submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a standardized form and manner specified by HHS.

(e) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) 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]

§ 156.1130 Quality improvement strategy.

(a) *General requirement.* A QHP issuer participating in an Exchange for 2 or more consecutive years must implement and report on a quality improvement strategy including a payment structure that provides increased reimbursement or other market-based incentives in accordance with the health care topic areas in section 1311(g)(1) of the Affordable Care Act, for each QHP offered in an Exchange, consistent with the guidelines developed by HHS under section 1311(g) of the Affordable Care Act.

(b) *Data requirement.* A QHP issuer must submit data that has been validated in a manner and timeframe specified by the Exchange to support the evaluation of quality improvement strategies in accordance with § 155.200(d) of this subchapter.

(c) *Timeline.* A QHP issuer must submit data annually to evaluate compliance with the standards for a quality improvement strategy in accordance with paragraph (a) of this section, in a manner and timeframe specified by the Exchange.

(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 (b) of this section to the U.S. Office of Personnel Management, in the manner and timeframe specified by the U.S. Office of Personnel Management.

[80 FR 10876, Feb. 27, 2015]

Subpart M—Qualified Health Plan Issuer Responsibilities

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

§ 156.1210 Dispute submission.

(a) *Responses to reports.* Within 90 calendar days of the date of a payment and collections report from HHS, the issuer must, in a form and manner specified by HHS or the State Exchange describe to HHS or the State Exchange (as applicable) any inaccuracies it identifies in the report.

(b) *Inaccuracies identified after 90-day period.* With respect to an inaccuracy described under paragraph (a) of this section that is identified and submitted to HHS or the State Exchange (as applicable) by the issuer after the end of the 90-day period described in such paragraph, HHS will consider and work with the issuer or the State Exchange (as applicable) to resolve the inaccuracy so long as—

(1) The issuer promptly notifies HHS or the State Exchange (as applicable) upon identifying the inaccuracy, but in no case later than 15 calendar days after identifying the inaccuracy; and

(2) The failure to identify the inaccuracy and submit it to HHS or the State Exchange (as applicable) in a timely manner was not unreasonable or due to the issuer's misconduct or negligence.

(c) *Deadline for describing inaccuracies.* To be eligible for resolution under paragraph (b) of this section, an issuer must describe all inaccuracies identified in a payment and collections report before the end of the 3-year period beginning at the end of the plan year to which the inaccuracy relates. For plan years 2015 through 2019, to be eligible for resolution under paragraph (b) of this section, an issuer must describe all inaccuracies identified in a payment and collections report before January 1, 2024. If a payment error is discovered after the timeframe set forth in this paragraph (c), the issuer must notify HHS, the State Exchange, or State-based Exchanges on the Federal platform (SBE–FP) (as applicable) and repay any overpayments to HHS.

(d) *Confirmation of HHS payment and collections reports.* At the end of each payment year, the issuer must, in a form and manner specified by HHS, confirm to HHS that the amounts identified in the most recent payment and collections report for the coverage year accurately reflect applicable payments owed by the issuer to the Federal Government and the payments owed to the issuer by the Federal Government, or that the issuer has disputed any identified inaccuracies.

[85 FR 29262, May 14, 2020, as amended at 86 FR 24294, May 5, 2021; 88 FR 25923, Apr. 27, 2023]

§ 156.1215 Payment and collections processes.

(a) *Netting of payments and charges for 2014.* In 2014, as part of its monthly payment and collections process, HHS will net payments owed to QHP issuers and their affiliates under the same taxpayer identification number against amounts due to the Federal government from the QHP issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of cost-sharing reductions, and payment of Federally-facilitated Exchange user fees.

(b) *Netting of payments and charges for later years.* As part of its payment and collections process, HHS may net payments owed to issuers and their affiliates operating under the same tax identification number against amounts due to the Federal government from the issuers and their affiliates under the same taxpayer identification number for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, payment of Federally-facilitated Exchange user fees, payment of State Exchanges utilizing the Federal platform user fees, and risk adjustment, reinsurance, and risk corridors payments and charges.

(c) *Determination of debt.* Any amount owed to the Federal government by an issuer and its affiliates for advance payments of the premium tax credit, advance payments of and reconciliation of cost-sharing reductions, Federally-facilitated Exchange user fees, including any fees for State-based Exchanges utilizing the Federal platform, risk adjustment, reinsurance, and risk corridors, after HHS nets amounts owed by the Federal government under these programs, is a determination of a debt.

[79 FR 13841, Mar. 11, 2014, as amended at 81 FR 12351, Mar. 8, 2016; 86 FR 24294, May 5, 2021]

§ 156.1220 Administrative appeals.

(a) *Requests for reconsideration*—(1) *Matters for reconsideration.* An issuer may file a request for reconsideration under this section to contest a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error only with respect to the following:

(i) The amount of advance payment of the premium tax credit, advance payment of cost-sharing reductions or Federally-facilitated Exchange user fees charge for a benefit year;

(ii) The amount of a risk adjustment payment or charge for a benefit year, including an assessment of risk adjustment user fees;

(iii) The amount of a reinsurance payment for a benefit year;

(iv) The amount of a risk adjustment default charge for a benefit year;

(v) The amount of a reconciliation payment or charge for cost-sharing reductions for a benefit year;

(vi) The amount of a risk corridors payment or charge for a benefit year;