(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;

(vii) The findings of a second validation audit as a result of risk adjustment data validation (if applicable) with respect to risk adjustment data for the 2016 benefit year and beyond; or

(viii) The calculation of a risk score error rate as a result of risk adjustment data validation with respect to risk adjustment data for the 2016 benefit year and beyond.

(2) *Materiality threshold.* Notwithstanding paragraph (a)(1) of this section, an issuer may file a request for reconsideration under this section only if the amount in dispute under paragraph (a)(1)(i) through (viii) of this section, as applicable, is equal to or exceeds 1 percent of the applicable payment or charge listed in such paragraphs (a)(1)(i) through (viii) of this section payable to or due from the issuer for the benefit year, or $10,000, whichever is less.

(3) *Time for filing a request for reconsideration.* The request for reconsideration must be filed in accordance with the following timeframes:

(i) For advance payments of the premium tax credit, advance payments of cost-sharing reductions, Federally-facilitated Exchange user fee charges, or State-based Exchanges utilizing the Federal platform fees, within 60 calendar days after the date of the final reconsideration notification specifying the aggregate amount of advance payments of the premium tax credit, advance payments of cost-sharing reductions, Federally-facilitated Exchange user fees, and State-based Exchanges utilizing the Federal platform fees for the applicable benefit year;

(ii) For a risk adjustment payment or charge, including an assessment of risk adjustment user fees, within 30 calendar days of the date of the notification under §153.310(e) of this subchapter;

(iii) For the findings of a second validation audit (if applicable), or the calculation of a risk score error rate as a result of risk adjustment data validation, within 30 calendar days of publication of the applicable benefit year's Summary Report of Benefit Year Risk Adjustment Data Validation Adjustments to Risk Adjustment Transfers;

(iv) For a reinsurance payment, within 30 calendar days of the date of the notification under §153.240(b)(1)(ii) of this subchapter;

(v) For a default risk adjustment charge, within 30 calendar days of the date of the notification of the default risk adjustment charge;

(vi) For reconciliation of the cost-sharing reduction portion of advance payments, within 60 calendar days of the date of the cost-sharing reduction reconciliation discrepancy resolution decision; and

(vii) For a risk corridors payment or charge, within 30 calendar days of the date of the notification under §153.510(d) of this subchapter.

(4) *Content of request.* (i) The request for reconsideration must specify the findings or issues specified in paragraph (a)(1) of this section that the issuer challenges, and the reasons for the challenge.

(ii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to a processing error by HHS, HHS's incorrect application of the relevant methodology, or HHS's mathematical error may be requested only if, to the extent the issue could have been previously identified, the issuer notified HHS of the dispute through the applicable process for reporting a discrepancy set forth in §§153.630(d)(2) and (3) and 153.710(d)(2) of this subchapter and §156.430(h)(1), it was so identified and remains unresolved.

(iii) Notwithstanding paragraph (a)(1) of this section, a reconsideration with respect to advance payments of the premium tax credit, advance payments of cost-sharing reductions, and Federally-facilitated Exchange user fees may be requested only if, to extent the issue could have been previously identified by the issuer to HHS under §156.1210, it was so identified and remains unresolved. An issuer may request reconsideration if it previously identified an issue under §156.1210 after the 15-calendar-day deadline, but late discovery of the issue was not due to misconduct on the part of the issuer.

(iv) The issuer may include in the request for reconsideration additional documentary evidence that HHS should consider. Such documents may not include data that was to have been filed by the applicable data submission

deadline, but may include evidence of timely submission.

(5) *Scope of review for reconsideration.* In conducting the reconsideration, HHS will review the appropriate payment and charge determinations, the evidence and findings upon which the determination was based, and any additional documentary evidence submitted by the issuer. HHS may also review any other evidence it believes to be relevant in deciding the reconsideration, which will be provided to the issuer with a reasonable opportunity to review and rebut the evidence. The issuer must prove its case by a preponderance of the evidence with respect to issues of fact.

(6) *Reconsideration decision.* HHS will inform the issuer of the reconsideration decision in writing. A reconsideration decision is final and binding for decisions regarding the advance payments of the premium tax credit, advance payment of cost-sharing reductions, or Federally-facilitated Exchange user fees. A reconsideration decision with respect to other matters is subject to the outcome of a request for informal hearing filed in accordance with paragraph (b) of this section.

(b) *Informal hearing.* An issuer may request an informal hearing before a CMS hearing officer to appeal HHS's reconsideration decision.

(1) *Manner and timing for request.* A request for an informal hearing must be made in writing and filed with HHS within 30 calendar days of the date of the reconsideration decision under paragraph (a)(5) of this section. If the last day of this period is not a business day, the request for an informal hearing must be made in writing and filed by the next applicable business day.

(2) *Content of request.* The request for informal hearing must include a copy of the reconsideration decision and must specify the findings or issues in the decision that the issuer challenges, and its reasons for the challenge. HHS may submit for review by the CMS hearing officer a statement of its reasons for the reconsideration decision.

(3) *Informal hearing procedures.* (i) The issuer will receive a written notice of the time and place of the informal hearing at least 15 calendar days before the scheduled date.

(ii) The CMS hearing officer will neither receive testimony nor accept any new evidence that was not presented with the reconsideration request and HHS statement under paragraph (b) of this section. The CMS hearing officer will review only the documentary evidence provided by the issuer and HHS, and the record that was before HHS when HHS made its reconsideration determination. The issuer may be represented by counsel in the informal hearing, and must prove its case by clear and convincing evidence with respect to issues of fact.

(4) *Decision of the CMS hearing officer.* The CMS hearing officer will send the informal hearing decision and the reasons for the decision to the issuer. The decision of the CMS hearing officer is final and binding, but is subject to the results of any Administrator's review initiated in accordance with paragraph (c) of this section.

(c) *Review by the Administrator of CMS.* (1) Either the issuer or CMS may request review by the Administrator of CMS of the CMS hearing officer's decision. A request for review of the CMS hearing officer's decision must be submitted to the Administrator of CMS within 15 calendar days of the date of the CMS hearing officer's decision, and must specify the findings or issues that the issuer or CMS challenges. The issuer or CMS may submit for review by the Administrator of CMS a statement supporting the decision of the CMS hearing officer.

(2) After receiving a request for review, the Administrator of CMS has the discretion to elect to review the CMS hearing officer's decision or to decline to review the CMS hearing officer's decision. If the Administrator of CMS elects to review the CMS hearing officer's decision, the Administrator of CMS will also review the statements of the issuer and CMS, and any other information included in the record of the CMS hearing officer's decision, and will determine whether to uphold, reverse, or modify the CMS hearing officer's decision. The issuer or CMS must prove its case by clear and convincing evidence for issues of fact. The Administrator of CMS will send the decision and the reasons for the decision to the issuer.

(3) The Administrator of CMS's determination is final and binding.

[79 FR 13841, Mar. 11, 2014, as amended at 80 FR 10876, Feb. 27, 2015; 81 FR 12352, Mar. 8, 2016; 81 FR 94182, Dec. 22, 2016; 86 FR 24294, May 5, 2021; 88 FR 25923, Apr. 27, 2023]

§ 156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

(a) A QHP issuer that is directly contacted by a potential applicant may, at the Exchange's option, enroll such applicant in a QHP in a manner that is considered through the Exchange. In order for the enrollment to be made directly with the issuer in a manner that is considered to be through the Exchange, the QHP issuer needs to comply with at least the following requirements:

(1) *QHP issuer general requirements.* (i) The QHP issuer follows the enrollment process for qualified individuals consistent with § 156.265.

(ii) The QHP issuer's Web site provides applicants the ability to view QHPs offered by the issuer with the data elements listed in § 155.205(b)(1)(i) through (viii) of this subchapter.

(iii) The QHP issuer's Web site clearly distinguishes between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(iv) The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to and describes how to access the Exchange Web site.

(v) The QHP issuer's Web site allows applicants to select and attest to an advance payment of the premium tax credit amount, if applicable, in accordance with § 155.310(d)(2) of this subchapter.

(2) [Reserved]

(b) *Direct enrollment in a Federally-facilitated Exchange.* The individual market Federally-facilitated Exchanges will permit issuers of QHPs in each Federally-facilitated Exchange to directly enroll applicants in a manner that is considered to be through the Exchange, pursuant to paragraph (a) of this section, to the extent permitted by applicable State law.

(1) The QHP issuer must comply with applicable requirements in § 155.221 of this subchapter.

(2) The QHP issuer must provide consumers with correct information, without omission of material fact, regarding the Federally-facilitated Exchanges, QHPs offered through the Federally-facilitated Exchanges, and insurance affordability programs, and refrain from marketing or conduct that is misleading (including by having a direct enrollment website that HHS determines could mislead a consumer into believing they are visiting *HealthCare.gov*), coercive, or discriminates based on race, color, national origin, disability, age, or sex.

[78 FR 54143, Aug. 30, 2013, as amended at 81 FR 94182, Dec. 22, 2016; 83 FR 17070, Apr. 17, 2018; 84 FR 17568, Apr. 25, 2019; 85 FR 37248, June 19, 2020]

§ 156.1240 Enrollment process for qualified individuals.

(a) *Premium payment.* A QHP issuer must—

(1) Follow the premium payment process established by the Exchange in accordance with § 155.240.

(2) At a minimum, for all payments in the individual market, accept paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method.

(3) For payments in the individual market made using a payment method described in paragraph (a)(2) of this section, accept premium payments made by or on behalf of an enrollee in connection with an individual coverage HRA (as described in § 146.123(b) of this subchapter) or qualified small employer health reimbursement arrangement (as described in section 9831(d)(2) of the Internal Revenue Code of 1986, as amended) in which the enrollee is enrolled.

(b) [Reserved]

[78 FR 54143, Aug. 30, 2013, as amended at 86 FR 6178, Jan. 19, 2021]