HealthAffairsBlog

CMS Releases FAQs On Transparency And Quality Rating Guidelines

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On August 3, CMS released at its REGTAP.info website (registration required), a series of frequently asked questions (FAQs), most of which provide additional detail on the transparency and quality rating guidelines released on July 25, 2016. The FAQs clarify that only qualified health plan insurers in consumer display pilot states (Michigan, Ohio, Oregon, Pennsylvania, Virginia, and Wisconsin) and in states with state-based marketplaces that display star ratings can use their star ratings in marketing materials. CMS will issue disclaimer language for insurers to use that will caution consumers that the display of the star-rating system is still being consumer tested.

The FAQs also clarify a point about the claims and appeals data that QHP and standalone dental plan insurers must submit under the transparency initiative in federally facilitated marketplace states and in state-based marketplace states that use the FFM enrollment platform: these data are for claims and appeals for services provided in 2015, not for services provided earlier for which a claim was processed in 2015. Insurers that are new to the marketplace for 2017 must complete the transparency template, including URLs for claims payment and other policies, but do not have to submit data since they would not have 2015 data. Initial transparency information must be submitted to September 2, 2016 and final data by September 23.

A Possible Link To *House V. Burwell*?

The most interesting FAQ is enigmatically entitled, “Can you clarify a Qualified Health Plan issuer’s obligations?” The answer states:

> Qualified health plan (QHP) issuers must meet certain statutory and regulatory standards. Issuers may not waive or alter their obligation to meet these standards by including language in their contracts with enrollees that is inconsistent with issuers’ obligations with respect to their QHPs. Any contractual language between an issuer and enrollee purporting to change or relieve an issuer of QHP obligations, including pending external litigation or other regulatory action, is inconsistent with QHP requirements and is a violation of the QHP agreement.

Although the FAQs do not say so directly, this FAQ may be aimed at insurers that are considering adding language to their policies that would permit them to cease applying cost-sharing reductions for eligible individuals should the courts ultimately rule for the House in *House v. Burwell*. The House lawsuit claims that the Department of Health and Human Services cannot reimburse insurers for reducing cost sharing in the absence of a specific appropriation.

The ACA is clear, however, that insurers must reduce cost sharing for eligible individuals and that this obligation is not dependent upon an insurer being reimbursed. The FAQ clarifies that insurers cannot avoid statutory or regulatory obligations such as this by contractual language. The FAQ is, however, classified in the REGTAP “state-based marketplace” subcategory, so it may be directed at a different dispute particular to a state-based marketplace.

FOLLOWING THE ACA

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