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Selected Federal Health Insurance Provisions

Volume II

Requirements Relating to Health Care Access

45 C.F.R. Parts 154 – 159

This is an unofficial compilation of selected Department of Health and Human Services ("HHS") regulations affecting health insurers codified in Title 45 Code of Federal Regulations Parts 154 through 159.

For Volume I, which includes 45 C.F.R. Parts 144-153, click here and see the second-to-last item under "Compiled Rules."

Note: Although reasonable effort has been made to compile these provisions as published by HHS, no assurance can be given that this compilation is a completely accurate restatement of the Federal health insurance provisions.

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TABLE OF CONTENTS

(*Click section for link to page.*)

CODE OF FEDERAL REGULATIONS TITLE 45—PUBLIC WELFARE AND HUMAN SERVICES

PART 154—HEALTH INSURANCE ISSUER RATE INCREASES: DISCLOSURE AND REVIEW REQUIREMENTS

Authority: Section 2794 of the Public Health Service Act (42 USC 300gg–94).

SUBPART A—GENERAL PROVISIONS

§ 154.101 Basis and scope.

(a) *Basis.* This part implements section 2794 of the Public Health Service (PHS) Act.

(b) *Scope.* This part establishes the requirements for health insurance issuers offering health insurance coverage in the small group or individual markets to report information concerning unreasonable rate increases to the Centers for Medicare & Medicaid Services (CMS). This part further establishes the process by which it will be determined whether the rate increases are unreasonable rate increases as defined in this part.

§ 154.102 Definitions.

As used in this part:

CMS means the Centers for Medicare & Medicaid Services.

Effective Rate Review Program means a State program that CMS has determined meets the requirements set forth in § 154.301(a) and (b) for the relevant market segment in the State.

Federal medical loss ratio standard means the applicable medical loss ratio standard for the State and market segment involved, determined under subpart B of 45 C.F.R. part 158.

Health insurance coverage has the meaning given the term in section 2791(b)(1) of the PHS Act.

Health insurance issuer has the meaning given the term in section 2791(b)(2) of the PHS Act.

Individual market has the meaning given the term in § 144.103 of this subchapter.

Plan has the meaning given the term in § 144.103 of this subchapter.

Product means a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies offered in a State. The term product includes any product that is discontinued and newly filed within a 12-month period when the changes to the product meet the standards of § 147.106(e)(2) or (3) of this subchapter (relating to uniform modification of coverage).

Rate increase means, with respect to rates filed—

(1) For coverage effective prior to January 1, 2017, any increase of the rates for a specific product offered in the individual or small group market.

(2) For coverage effective on or after January 1, 2017, any increase of the rates for a specific product or plan within a product offered in the individual or small group market.

Rate increase subject to review means a rate increase that meets the criteria set forth in § 154.200.

Secretary means the Secretary of the Department of Health and Human Services.

Small group market has the meaning given the term in § 144.103 of this subchapter.

State means each of the 50 States and the District of Columbia.

Unreasonable rate increase means:

(1) When CMS is conducting the review required by this part, a rate increase that CMS determines under § 154.205 is:

(i) An excessive rate increase;

(ii) An unjustified rate increase; or

(iii) An unfairly discriminatory rate increase.

(2) When CMS adopts the determination of a State that has an Effective Rate Review Program, a rate increase that the State determines is excessive, unjustified, unfairly discriminatory, or otherwise unreasonable as provided under applicable State law.

§ 154.103 Applicability.

(a) *In general.* The requirements of this part apply to health insurance issuers offering health insurance coverage in the individual market and small group market.

(b) *Exceptions.* The requirements of this part do not apply to—

(1) Grandfathered health plan coverage as defined in § 147.140 of this subchapter;

(2) Excepted benefits as described in section 2791(c) of the PHS Act; and

(3) For coverage effective on or after July 1, 2018, student health insurance coverage as defined in § 147.145 of this subchapter.

SUBPART B—DISCLOSURE AND REVIEW PROVISIONS

§ 154.200 Rate increases subject to review.

(a) A rate increase filed in a State, or effective in a State that does not require a rate increase to be filed, is subject to review if:

(1) The rate increase is 15 percent or more applicable to a 12-month period that begins on January 1, as calculated under paragraph (b) of this section; or

(2) The rate increase meets or exceeds a State-specific threshold applicable to a 12-month period that begins on January 1, as calculated under paragraph (b) of this section, determined by the Secretary. A State-specific threshold shall be based on factors impacting rate increases in a State to the extent that the data relating to such State-specific factors are available by August 1 of the preceding year. States interested in proposing a State-specific threshold greater than the Federal default stated in paragraph (a)(1) of this section are required to submit a proposal for approval of such threshold to the Secretary by August 1 of the preceding year, in the form and manner specified by the Secretary.

(b) A rate increase meets or exceeds the applicable threshold set forth in paragraph (a) of this section if the average increase, including premium rating factors described in § 147.102 of this subchapter, for all enrollees weighted by premium volume for any plan within the product meets or exceeds the applicable threshold.

(c) If a rate increase that does not otherwise meet or exceed the threshold under paragraph (b) of this section meets or exceeds the threshold when combined with a previous increase or increases during the 12-month period preceding the date on which the rate increase would become effective, then the rate increase must be considered to meet or exceed the threshold and is subject to review under § 154.210, and such review shall include a review of the aggregate rate increases during the applicable 12-month period.

§ 154.205 Unreasonable rate increases.

(a) When CMS reviews a rate increase subject to review under § 154.210(a), CMS will determine that the rate increase is an unreasonable rate increase if the increase is an excessive rate increase, an unjustified rate increase, or an unfairly discriminatory rate increase.

(b) The rate increase is an excessive rate increase if the increase causes the premium charged for the health insurance coverage to be unreasonably high in relation to the benefits provided under the coverage. In determining whether the rate increase causes the premium charged to be unreasonably high in relationship to the benefits provided, CMS will consider:

(1) Whether the rate increase results in a projected medical loss ratio below the Federal medical loss ratio standard in the applicable market to which the rate increase applies, after accounting for any adjustments allowable under Federal law;

(2) Whether one or more of the assumptions on which the rate increase is based is not supported by substantial evidence; and

(3) Whether the choice of assumptions or combination of assumptions on which the rate increase is based is unreasonable.

(c) The rate increase is an unjustified rate increase if the health insurance issuer provides data or documentation to CMS in connection with the increase that is incomplete, inadequate or otherwise does not provide a basis upon which the reasonableness of an increase may be determined.

(d) The rate increase is an unfairly discriminatory rate increase if the increase results in premium differences between insureds within similar risk categories that:

(1) Are not permissible under applicable State law; or

(2) In the absence of an applicable State law, do not reasonably correspond to differences in expected costs.

§ 154.210 Review of rate increases subject to review by CMS or by a State.

(a) Except as provided in paragraph (b) of this section, CMS will review a rate increase subject to review to determine whether it is unreasonable, as required by this part.

(b) CMS will adopt a State's determination of whether a rate increase is an unreasonable rate increase, if the State:

(1) Has an Effective Rate Review Program as described in § 154.301; and

(2) The State provides to CMS, on a form and in a manner prescribed by the Secretary, its final determination of whether a rate increase is unreasonable, which must include a brief explanation of how its analysis of the relevant factors set forth in § 154.301(a)(3) caused it to arrive at that determination, within five business days following the State's final determination.

(c) CMS will post and maintain on its Web site a list of the States with market segments that meet the requirements of paragraph (b) of this section.

§ 154.215 Submission of rate filing justification.

(a) A health insurance issuer must submit to CMS and to the applicable State (if the State accepts such submissions) the information specified below on a form and in a manner prescribed by the Secretary.

(1) For all single risk pool products, including new and discontinuing products, the Unified Rate Review Template, as described in paragraph (d) of this section;

(2) For each single risk pool product that includes a plan that is subject to a rate increase, regardless of the size of the increase, the unified rate review template and actuarial memorandum, as described in paragraph (f) of this section;

(3) For each single risk pool product that includes a plan with a rate increase that is subject to review under § 154.210, all parts of the Rate Filing Justification, as described in paragraph (b) of this section

(b) A Rate Filing Justification includes one or more of the following:

(2) Written description justifying the rate increase (Part II), as described in paragraph (e) of this section.

(3) Rating filing documentation (Part III), as described in paragraph (f) of this section.

(c) [Reserved]

(d) Content of unified rate review template (Part I): The unified rate review template must include the following as determined appropriate by the Secretary:

(1) Historical and projected claims experience.

(2) Trend projections related to utilization, and service or unit cost.

(3) Any claims assumptions related to benefit changes.

(4) Allocation of the overall rate increase to claims and non-claims costs.

(5) Per enrollee per month allocation of current and projected premium.

(6) Three year history of rate increases for the product associated with the rate increase.

(e) Content of written description justifying the rate increase (Part II): The written description of the rate increase must include a simple and brief narrative describing the data and assumptions that were used to develop the rate increase and including the following:

(1) Explanation of the most significant factors causing the rate increase, including a brief description of the relevant claims and non-claims expense increases reported in the rate increase summary.

(2) Brief description of the overall experience of the policy, including historical and projected expenses, and loss ratios.

(f) Content of rate filing documentation (Part III): The rate filing documentation must include an actuarial memorandum that contains the reasoning and assumptions supporting the data contained in Part I of the Rate Filing Justification. Parts I and III must be sufficient to conduct an examination satisfying the requirements of § 154.301(a)(3) and (4) and determine whether the rate increase is an unreasonable increase. Instructions concerning the requirements for the rate filing documentation will be provided in guidance issued by CMS.

(g) If the level of detail provided by the issuer for the information under paragraphs (d) and (f) of this section does not provide sufficient basis for CMS to determine whether the rate increase is an unreasonable rate increase when CMS reviews a rate increase subject to review under § 154.210(a), CMS will request the additional information necessary to make its determination. The health insurance issuer must provide the requested information to CMS within 10 business days following its receipt of the request.

(h) Posting of the disclosure on the CMS Web site:

(1) CMS promptly will make available to the public on its Web site the information contained in Part II of each Rate Filing Justification.

(2) CMS will make available to the public on its website the information contained in Parts I and III of each Rate Filing Justification that is not a trade secret or confidential commercial or financial information as defined in HHS's Freedom of Information Act regulations, 45 CFR 5.31(d).

(3) CMS will include a disclaimer on its Web site with the information made available to the public that explains the purpose and role of the Rate Filing Justification.

(4) CMS will include information on its Web site concerning how the public can submit comments on the proposed rate increases that CMS reviews.

§ 154.220 Timing of providing the rate filing Justification.

A health insurance issuer must submit applicable sections of the Rate Filing Justification for all single risk pool coverage in the individual or small group market, as follows:

(a) For rate increases for coverage effective prior to January 1, 2016:

(1) If a State requires that a proposed rate increase be filed with the State prior to the implementation of the rate, the health insurance issuer must submit to CMS and the applicable State the Rate Filing Justification on the date on which the health insurance issuer submits the proposed rate increase to the State.

(2) For all other States, the health insurance issuer must submit to CMS and the State the Rate Filing Justification prior to the implementation of the rate increase.

(b) For coverage effective on or after January 1, 2017, by the earlier of the following:

(1) The date by which the State requires submission of a rate filing; or

(2) The date specified in guidance by the Secretary.

§ 154.225 Determination by CMS or a State of an unreasonable rate increase.

(a) When CMS receives a Rate Filing Justification for a rate increase subject to review and CMS reviews the rate increase under § 154.210(a), CMS will make a timely determination whether the rate increase is an unreasonable rate increase.

(1) CMS will post on its Web site its final determination and a brief explanation of its analysis, consistent with the form and manner prescribed by the Secretary under § 154.210(b)(2), within five business days following its final determination.

(2) If CMS determines that the rate increase is an unreasonable rate increase, CMS will also provide its final determination and brief explanation to the health insurance issuer within five business days following its final determination.

(b) If a State conducts a review under § 154.210(b), CMS will adopt the State's determination of whether a rate increase is unreasonable and post on the CMS Web site the State's final determination described in § 154.210(b)(2).

(c) If a State determines that the rate increase is an unreasonable rate increase and the health insurance issuer is legally permitted to implement the unreasonable rate increase under applicable State law, CMS will provide the State's final determination and brief explanation to the health insurance issuer within five business days following CMS's receipt thereof.

§ 154.230 Submission and posting of Final Justifications for unreasonable rate increases.

(a) If a health insurance issuer receives from CMS a final determination by CMS or a State that a rate increase is an unreasonable rate increase, and the health insurance issuer declines to implement the rate increase or chooses to implement a lower increase, the health insurance issuer must submit to CMS timely notice that it will not implement the rate increase or that it will implement a lower increase on a form and in the manner prescribed by the Secretary.

(b) If a health insurance issuer implements a lower increase as described in paragraph (a) of this section and the lower increase does not meet or exceed the applicable threshold under § 154.200, such lower increase is not subject to this part. If the lower increase meets or exceeds the applicable threshold, the health insurance issuer must submit a new Rate Filing Justification under this part.

(c) If a health insurance issuer implements a rate increase determined by CMS or a State to be unreasonable, within the later of 10 business days after the implementation of such increase or the health insurance issuer's receipt of CMS's final determination that a rate increase is an unreasonable rate increase, the health insurance issuer must:

(1) Submit to CMS a Final Justification in response to CMS's or the State's final determination, as applicable. The information in the Final Justification must be consistent with the information submitted in the Rate Filing Justification supporting the rate increase; and

(2) Prominently post on its Web site the following information on a form and in the manner prescribed by the Secretary:

(i) The information made available to the public by CMS and described in § 154.215(h);

(ii) CMS's or the State's final determination and brief explanation described in § 154.225(a) and § 154.210(b)(2), as applicable; and

(iii) The health insurance issuer's Final Justification for implementing an increase that has been determined to be unreasonable by CMS or the State, as applicable.

(3) The health insurance issuer must continue to make this information available to the public on its Web site for at least three years.

(d) CMS will post all Final Justifications on the CMS Web site. This information will remain available to the public on the CMS Web site for three years.

SUBPART C—EFFECTIVE RATE REVIEW PROGRAMS

§ 154.301 CMS's determinations of Effective Rate Review Programs.

(a) *Effective Rate Review Program.* In evaluating whether a State has an Effective Rate Review Program, CMS will apply the following criteria for the review of rates for the small group market and the individual market, and also, as applicable depending on State law, the review of rates for different types of products within those markets:

(1) The State receives from issuers data and documentation in connection with rate increases that are sufficient to conduct the examination described in paragraph (a)(3) of this section.

(2) The State conducts an effective and timely review of the data and documentation submitted by a health insurance issuer in support of a proposed rate increase.

(3) The State's rate review process includes an examination of:

(i) The reasonableness of the assumptions used by the health insurance issuer to develop the proposed rate increase and the validity of the historical data underlying the assumptions.

(ii) The health insurance issuer's data related to past projections and actual experience.

(iii) The reasonableness of assumptions used by the health insurance issuer to estimate the rate impact of the reinsurance and risk adjustment programs under sections 1341 and 1343 of the Affordable Care Act.

(iv) The health insurance issuer's data related to implementation and ongoing utilization of a market-wide single risk pool, essential health benefits, actuarial values and other market reform rules as required by the Affordable Care Act.

(4) The examination must take into consideration the following factors to the extent applicable to the filing under review:

(i) The impact of medical trend changes by major service categories.

(ii) The impact of utilization changes by major service categories.

(iii) The impact of cost-sharing changes by major service categories, including actuarial values.

(iv) The impact of benefit changes, including essential health benefits and non-essential health benefits.

(v) The impact of changes in enrollee risk profile and pricing, including rating limitations for age and tobacco use under section 2701 of the Public Health Service Act.

(vi) The impact of any overestimate or underestimate of medical trend for prior year periods related to the rate increase.

(vii) The impact of changes in reserve needs.

(viii) The impact of changes in administrative costs related to programs that improve health care quality.

(ix) The impact of changes in other administrative costs.

(x) The impact of changes in applicable taxes, licensing or regulatory fees.

(xi) Medical loss ratio.

(xii) The health insurance issuer's capital and surplus.

(xiii) The impacts of geographic factors and variations.

(xiv) The impact of changes within a single risk pool to all products or plans within the risk pool.

(xv) The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

(5) The State's determination of whether a rate increase is unreasonable is made under a standard that is set forth in State statute or regulation.

(b) *Public disclosure and input.* (1) In addition to satisfying the provisions in paragraph (a) of this section, a State with an Effective Rate Review Program must provide:

(i) For proposed rate increases subject to review, access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification that CMS makes available on its Web site (or provide CMS's Web address for such information), and have a mechanism for receiving public comments on those proposed rate increases, no later than the date specified in guidance by the Secretary.

(ii) Beginning with rates filed for coverage effective on or after January 1, 2016, for all final rate increases (including those not subject to review), access from its Web site to at least the information contained in Parts I, II, and III of the Rate Filing Justification (as applicable) that CMS makes available on its Web site (or provide CMS's Web address for such information), no later than the first day of the annual open enrollment period in the individual market for the applicable calendar year.

(2) If a State intends to make the information in paragraph (b)(1)(i) of this section available to the public prior to the date specified by the Secretary, or if it intends to make the information in paragraph (b)(1)(ii) of this section available to the public prior to the first day of the annual open enrollment period in the individual market for the applicable calendar year, the State must notify CMS in writing, no later than five (5) business days prior to the date it intends to make the information public, of its intent to do so and the date it intends to make the information public.

(3) A State with an Effective Rate Review Program must ensure the information in paragraphs (b)(1)(i) and (ii) of this section is made available to the public at a uniform time for all proposed and final rate increases, as applicable, in the relevant market segment and without regard to whether coverage is offered through or outside an Exchange.

(c) CMS will determine whether a State has an Effective Rate Review Program for each market based on information available to CMS that a rate review program meets the criteria described in paragraphs (a) and (b) of this section.

(d) CMS reserves the right to evaluate from time to time whether, and to what extent, a State's circumstances have changed such that it has begun to or has ceased to satisfy the criteria set forth in paragraphs (a) and (b) of this section.

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PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

Authority: 42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083.

SUBPART A—GENERAL PROVISIONS.

§ 155.10 Basis and scope.

(a) *Basis.* This part is based on the following sections of title I of the Affordable Care Act:

(1) 1301. Qualified health plan defined

(2) 1302. Essential health benefits requirements

(3) 1303. Special rules

(4) 1304. Related definitions

(5) 1311. Affordable choices of health benefit plans.

(6) 1312. Consumer choice

(7) 1313. Financial integrity.

(8) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(9) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(10) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(11) 1334. Multi-State plans.

(12) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(13) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(14) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(15) 1413. Streamlining of procedures for enrollment through an exchange and State Medicaid, CHIP, and health subsidy programs.

(b) *Scope.* This part establishes minimum standards for the establishment of an Exchange, minimum Exchange functions, eligibility determinations, enrollment periods, minimum SHOP functions, certification of QHPs, and health plan quality improvement.

§ 155.20 Definitions.

The following definitions apply to this part:

Advance payments of the premium tax credit means payment of the tax credit authorized by 26 U.S.C. 36B and its implementing regulations, which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with section 1412 of the Affordable Care Act.

Affordable Care Act means the Patient Protection and Affordable Care Act of 2010 (Pub. L. 111–148), as amended by the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111– 152).

Agent or broker means a person or entity licensed by the State as an agent, broker or insurance producer.

Agent or broker direct enrollment technology provider means a type of web-broker business entity that is not a licensed agent or broker under State law and has been engaged or created by, or is owned by an agent or broker, to provide technology services to facilitate participation in direct enrollment under §§ 155.220(c)(3) and 155.221.

Annual open enrollment period means the period each year during which a qualified individual may enroll or change coverage in a QHP through the Exchange.

Applicant means:

(1) An individual who is seeking eligibility for him or herself through an application submitted to the Exchange, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part, or transmitted to the Exchange by an agency administering an insurance affordability program for at least one of the following:

(i) Enrollment in a QHP through the Exchange; or

(ii) Medicaid, CHIP, and the BHP, if applicable.

(2) For SHOP:

(i) An employer seeking eligibility to purchase coverage through the SHOP; or

(ii) An employer, employee, or a former employee seeking eligibility for enrollment in a QHP through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, seeking eligibility to enroll his or her dependents in a QHP through the SHOP.

Application filer means an applicant, an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in 26 CFR 1.36B–1(d), an authorized representative of an applicant, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant, excluding those individuals seeking eligibility for an exemption from the individual shared responsibility payment pursuant to subpart G of this part.

Benefit year means a calendar year for which a health plan provides coverage for health benefits.

Catastrophic plan means a health plan described in section 1302(e) of the Affordable Care Act.

Code means the Internal Revenue Code of 1986.

Cost sharing means any expenditure required by or on behalf of an enrollee with respect to essential health benefits; such term includes deductibles, coinsurance, copayments, or similar charges, but excludes premiums, balance billing amounts for non-network providers, and spending for non-covered services.

Cost-sharing reductions means reductions in cost sharing for an eligible individual enrolled in a silver level plan in the Exchange or for an individual who is an Indian enrolled in a QHP in the Exchange.

Direct enrollment entity means an entity that an Exchange permits to assist consumers with direct enrollment in qualified health plans offered through the Exchange in a manner considered to be through the Exchange as authorized by § 155.220(c)(3), § 155.221, or § 156.1230 of this subchapter.

Direct enrollment entity application assister means an employee, contractor, or agent of a direct enrollment entity who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Educated health care consumer has the meaning given the term in section 1304(e) of the Affordable Care Act.

Eligible employer-sponsored plan has the meaning given the term in section 5000A(f)(2) of the Code.

Employee has the meaning given to the term in section 2791 of the PHS Act.

Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term includes employers with one or more employees. All persons treated as a single employer under subsection (b), (c), (m), or (o) of section 414 of the Code are treated as one employer.

Employer contributions means any financial contributions towards an employer sponsored health plan, or other eligible employer-sponsored benefit made by the employer including those made by salary reduction agreement that is excluded from gross income.

Enrollee means a qualified individual or qualified employee enrolled in a QHP. Enrollee also means the dependent of a qualified employee enrolled in a QHP through the SHOP, and any other person who is enrolled in a QHP through the SHOP, consistent with

applicable law and the terms of the group health plan. Provided that at least one employee enrolls in a QHP through the SHOP, enrollee also means a business owner enrolled in a QHP through the SHOP, or the dependent of a business owner enrolled in a QHP through the SHOP.

Exchange means a governmental agency or non-profit entity that meets the applicable standards of this part and makes QHPs available to qualified individuals and/or qualified employers. Unless otherwise identified, this term includes an Exchange serving the individual market for qualified individuals and a SHOP serving the small group market for qualified employers, regardless of whether the Exchange is established and operated by a State (including a regional Exchange or subsidiary Exchange) or by HHS.

Exchange Blueprint means information submitted by a State, an Exchange, or a regional Exchange that sets forth how an Exchange established by a State or a regional Exchange meets the Exchange approval standards established in § 155.105(b) and demonstrates operational readiness of an Exchange as described in § 155.105(c)(2).

Exchange service area means the area in which the Exchange is certified to operate, in accordance with the standards specified in subpart B of this part.

Federal platform agreement means an agreement between a State Exchange and HHS under which a State Exchange agrees to rely on the Federal platform to carry out select Exchange functions.

Federally-facilitated Exchange means an Exchange established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Federally-facilitated SHOP means a Small Business Health Options Program established and operated within a State by the Secretary under section 1321(c)(1) of the Affordable Care Act.

Full-time employee has the meaning given in section 4980H (c)(4) of the Code effective for plan years beginning on or after January 1, 2016, except for operations of a Federally-facilitated SHOP for which it is effective for plan years beginning on or after January 1, 2014 and in connection with open enrollment activities beginning October 1, 2013.

Grandfathered health plan has the meaning given the term in § 147.140.

Group health plan has the meaning given to the term in § 144.103.

Health insurance issuer or *issuer* has the meaning given to the term in § 144.103.

Health insurance coverage has the meaning given to the term in § 144.103.

Health plan has the meaning given to the term in section 1301(b)(1) of the Affordable Care Act.

Individual market has the meaning given the term in section 1304(a)(2) of the Affordable Care Act.

Initial open enrollment period means the period during which a qualified individual may enroll in coverage through the Exchange for coverage during the 2014 benefit year.

Issuer application assister means an employee, contractor, or agent of a QHP issuer who is not licensed as an agent, broker, or producer under State law and who assists individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange or for insurance affordability programs.

Large employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least 51 employees on business days during the preceding calendar year and who employs at least 1 employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a large employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define large employer by substituting "101 employees" for "51 employees." The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

Lawfully present has the meaning given the term in § 152.2.

Minimum essential coverage has the meaning given in section 5000A(f) of the Code.

Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the standards described in § 155.210.

Plan year means a consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.

Plain language has the meaning given to the term in section 1311(e)(3)(B) of the Affordable Care Act.

Qualified employee means any employee or former employee of a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP for himself or herself and, if the qualified employer offers dependent coverage through the SHOP, for his or her dependents.

Qualified employer means a small employer that elects to make, at a minimum, all full-time employees of such employer eligible for one or more QHPs in the small group market offered through a SHOP. Beginning in 2017, if a State allows large employers to purchase coverage through the SHOP, the term "qualified employer" shall include a large employer that elects to make all full-time employees of such employer eligible for one or more QHPs in the large group market offered through the SHOP.

Qualified health plan or *QHP* means a health plan that has in effect a certification that it meets the standards described in subpart C of part 156 issued or recognized by each Exchange through which such plan is offered in accordance with the process described in subpart K of part 155.

Qualified health plan issuer or *QHP issuer* means a health insurance issuer that offers a QHP in accordance with a certification from an Exchange.

Qualified health plan issuer direct enrollment technology provider means a business entity that provides technology services or provides access to an information technology platform to QHP issuers to facilitate participation in direct enrollment under §§ 155.221 or 156.1230, including a web-broker that provides services as a direct enrollment technology provider to QHP issuers. A QHP issuer direct enrollment technology provider that provides technology services or provides access to an information technology platform to a QHP issuer will be a downstream or delegated entity of the QHP issuer that participates or applies to participate as a direct enrollment entity.

Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll through the Exchange in a QHP in the individual market.

SHOP means a Small Business Health Options Program operated by an Exchange through which a qualified employer can provide its employees and their dependents with access to one or more QHPs.

Small employer means, in connection with a group health plan with respect to a calendar year and a plan year, an employer who employed an average of at least one but not more than 50 employees on business days during the preceding calendar year and who employs at least one employee on the first day of the plan year. In the case of an employer that was not in existence throughout the preceding calendar year, the determination of whether the employer is a small employer is based on the average number of employees that it is reasonably expected the employer will employ on business days in the current calendar year. A State may elect to define small employer by substituting "100 employees" for "50 employees." The number of employees must be determined using the method set forth in section 4980H(c)(2) of the Code.

Small group market has the meaning given to the term in section 1304(a)(3) of the Affordable Care Act.

Special enrollment period means a period during which a qualified individual or enrollee who experiences certain qualifying events may enroll in, or change enrollment in, a QHP through the Exchange outside of the initial and annual open enrollment periods. *State* means each of the 50 States and the District of Columbia.

Standardized option means a QHP offered for sale through an individual market Exchange that either—

(1) Has a standardized cost-sharing structure specified by HHS in rulemaking; or

(2) Has a standardized cost-sharing structure specified by HHS in rulemaking that is modified

only to the extent necessary to align with high deductible health plan requirements under section 223 of the Internal Revenue Code of 1986, as amended, or the applicable annual limitation on cost sharing and HHS actuarial value requirements.

Web-broker means an individual agent or broker, group of agents or brokers, or business entity registered with an Exchange under § 155.220(d)(1) that develops and hosts a non-Exchange website that interfaces with an Exchange to assist consumers with direct enrollment in QHPs offered through the Exchange as described in § 155.220(c)(3) or § 155.221. The term also includes an agent or broker direct enrollment technology provider.

SUBPART B—GENERAL STANDARDS RELATED TO THE ESTABLISHMENT OF AN EXCHANGE

§ 155.100 Establishment of a State Exchange.

(a) *General requirements.* Each State may elect to establish:

(1) An Exchange that facilitates the purchase of health insurance coverage in QHPs in the individual market and that provides for the establishment of a SHOP; or

(2) An Exchange that provides only for the establishment of a SHOP.

(b) *Timing.* * For plan years beginning on or after January 1, 2015, any State may elect to establish an Exchange that provides only for the establishment of a SHOP, pursuant to the process in § 155.106(a).

[* First sentence omitted: not applicable after 2015 plan year.]

(c) *Eligible Exchange entities.* The Exchange must be a governmental agency or non-profit entity established by a State, consistent with § 155.110.

§ 155.105 Approval of a State Exchange.

(a) *State Exchange approval requirement.* Each State Exchange must be approved by HHS by no later than January 1, 2013 to offer QHPs on January 1, 2014, and thereafter required in accordance with § 155.106. HHS may consult with other Federal Government agencies in determining whether to approve an Exchange.

(b) *State Exchange approval standards.* HHS will approve the operation of an Exchange established by a State provided that it meets the following standards:

(1) The Exchange is able to carry out the required functions of an Exchange consistent with subparts C, D, E, F, G, H, and K of this part unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2), in which case the Exchange must perform the minimum functions described in subpart H and all applicable provisions of other subparts referenced therein;

(2) The Exchange is capable of carrying out the information reporting requirements in accordance with section 36B of the Code, unless the State is approved to operate only a SHOP by HHS pursuant to § 155.100(a)(2); and

(3) The entire geographic area of the State is in the service area of an Exchange, or multiple Exchanges consistent with § 155.140(b).

(c) *State Exchange approval process.* In order to have its Exchange approved, a State must:

(1) Elect to establish an Exchange by submitting, in a form and manner specified by HHS, an Exchange Blueprint that sets forth how the Exchange meets the standards outlined in paragraph (b) of this section; and

(2) Demonstrate operational readiness to execute its Exchange Blueprint through a readiness assessment conducted by HHS.

(d) *State Exchange approval.* Each Exchange must receive written approval or conditional approval of its Exchange Blueprint and its performance under the operational readiness assessment consistent with paragraph (c) of this section in order to be considered an approved Exchange.

(e) *Significant changes to Exchange Blueprint.* The State must notify HHS in writing before making a significant change to its Exchange Blueprint; no significant change to an Exchange Blueprint may be

effective until it is approved by HHS in writing or 60 days after HHS receipt of a completed request. For good cause, HHS may extend the review period by an additional 30 days to a total of 90 days. HHS may deny a request for a significant change to an Exchange Blueprint within the review period.

(f) *HHS operation of an Exchange.* (1) If a State does not elect to operate an Exchange under § 155.100(a)(1) or an electing State does not have an approved or conditionally approved Exchange pursuant to § 155.100(a)(1) by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State. In this case, the requirements in § 155.120(c), § 155.130 and subparts C, D, E, F, G, H, and K of this part will apply.

(2) If an electing State has an approved or conditionally approved Exchange pursuant to § 155.100(a)(2) by January 1, 2013, HHS must (directly or through agreement with a not-for-profit entity) establish and operate an Exchange that facilitates the purchase of health insurance coverage in QHPs in the individual market and operate such Exchange within the State. In this case, the requirements in § 155.120(c), § 155.130 and subparts C, D, E, F, G, and K of this part will apply to the Exchange operated by HHS.

§ 155.106 Election to operate an Exchange after 2014.

(a) *Election to operate an Exchange.* Except as provided in paragraph (c) of this section, a State electing to seek approval of its Exchange must:

(1) Comply with the State Exchange approval requirements and process set forth in § 155.105;

(2) Submit an Exchange Blueprint application for HHS approval at least 15 months prior to the date on which the Exchange proposes to begin open enrollment as a State Exchange;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange would begin open enrollment as a State Exchange;

(4) Develop a plan jointly with HHS to facilitate the transition to a State Exchange; and

(5) If the open enrollment period for the year the State intends to begin operating an SBE has not been established, this deadline must be calculated based on the date open enrollment began or will begin in the year in which the State is submitting the Blueprint application.

(b) *Transition process for State Exchanges that cease operations.* If a State intends to cease operation of its Exchange, HHS will operate the Exchange on behalf of the State. Therefore, a State that intends to cease operations of its Exchange must:

(1) Notify HHS that it will no longer operate an Exchange at least 12 months prior to ceasing operations; and

(2) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

(c) *Process for State Exchanges that seek to utilize the Federal platform for select functions.* States may seek approval to operate a State Exchange utilizing the Federal platform for only the individual market. A State seeking approval to operate a State Exchange utilizing the Federal platform for the individual market to support select functions through a Federal platform agreement under § 155.200(f) must:

(1) If the State Exchange does not have a conditionally approved Exchange Blueprint application, submit one for HHS approval at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(2) If the State Exchange has a conditionally approved Exchange Blueprint application, submit any significant changes to that application for HHS approval, in accordance with § 155.105(e), at least 3 months prior to the date on which the Exchange proposes to begin open enrollment as an SBE–FP;

(3) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment prior to the date on which the Exchange proposes to begin open enrollment as a State-based Exchanges on the Federal platform (SBE–FP), in accordance with HHS rules in this chapter, as a State Exchange utilizing the Federal platform;

(4) Prior to approval, or conditional approval, of the Exchange Blueprint, execute a Federal platform agreement for utilizing the Federal platform for select functions; and

(5) Coordinate with HHS on a transition plan to be developed jointly between HHS and the State.

§ 155.110 Entities eligible to carry out Exchange functions.

(a) *Eligible contracting entities.* The State may elect to authorize an Exchange established by the State to enter into an agreement with an eligible entity to carry out one or more responsibilities of the Exchange. Eligible entities are:

(1) An entity:

(i) Incorporated under, and subject to the laws of, one or more States;

(ii) That has demonstrated experience on a State or regional basis in the individual and small group health insurance markets and in benefits coverage; and

(iii) Is not a health insurance issuer or treated as a health insurance issuer under subsection (a) or (b) of section 52 of the Code of 1986 as a member of the same controlled group of corporations (or under common control with) as a health insurance issuer; or

(2) The State Medicaid agency, or any other State agency that meets the qualifications of paragraph (a)(1) of this section.

(b) *Responsibility.* To the extent that an Exchange establishes such agreements, the Exchange remains responsible for ensuring that all Federal requirements related to contracted functions are met.

(c) *Governing board structure.* If the Exchange is an independent State agency or a non-profit entity established by the State, the State must ensure that the Exchange has in place a clearly-defined governing board that:

(1) Is administered under a formal, publicly-adopted operating charter or by-laws;

(2) Holds regular public governing board meetings that are announced in advance;

(3) Represents consumer interests by ensuring that overall governing board membership:

(i) Includes at least one voting member who is a consumer representative;

(ii) Is not made up of a majority of voting representatives with a conflict of interest, including representatives of health insurance issuers or agents or brokers, or any other individual licensed to sell health insurance; and

(4) Ensures that a majority of the voting members on its governing board have relevant experience in health benefits administration, health care finance, health plan purchasing, health care delivery system administration, public health, or health policy issues related to the small group and individual markets and the uninsured.

(d) *Governance principles.* (1) The Exchange must have in place and make publicly available a set of guiding governance principles that include ethics, conflict of interest standards, accountability and transparency standards, and disclosure of financial interest.

(2) The Exchange must implement procedures for disclosure of financial interests by members of the Exchange board or governance structure.

(e) *SHOP independent governance.* (1) A State may elect to create an independent governance and administrative structure for the SHOP, consistent with this section, if the State ensures that the SHOP coordinates and shares relevant information with the Exchange operating in the same service area.

(2) If a State chooses to operate its Exchange and SHOP under a single governance or administrative structure, it must ensure that the Exchange has adequate resources to assist individuals and small employers in the Exchange.

(f) *HHS review.* HHS may periodically review the accountability structure and governance principles of a State Exchange.

§ 155.120 Non-interference with Federal law and non-discrimination standards.

(a) *Non-interference with Federal law.* An Exchange must not establish rules that conflict with or prevent the application of regulations promulgated by HHS under subtitle D of title I of the Affordable Care Act.

(b) *Non-interference with State law.* Nothing in parts 155, 156, or 157 of this subchapter shall be construed to preempt any State law that does not prevent the application of the provisions of title I of the Affordable Care Act.

(c) *Non-discrimination.* (1) In carrying out the requirements of this part, the State and the Exchange must:

(i) Comply with applicable nondiscrimination statutes; and

(ii) Not discriminate based on race, color, national origin, disability, age, or sex.

(2) Notwithstanding the provisions of paragraph (c)(1)(ii) of this section, an organization that receives Federal funds to provide services to a defined population under the terms of Federal legal authorities that participates in the certified application counselor program under § 155.225 may limit its provision of certified application counselor services to the same defined population, but must comply with paragraph (c)(1)(ii) of this section with respect to the provision of certified application counselor services to that defined population. If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the individual to other Exchange-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with paragraph (c)(1)(ii) of this section.

§ 155.130 Stakeholder consultation.

The Exchange must regularly consult on an ongoing basis with the following stakeholders:

(a) Educated health care consumers who are enrollees in QHPs;

(b) Individuals and entities with experience in facilitating enrollment in health coverage;

(c) Advocates for enrolling hard to reach populations, which include individuals with mental health or substance abuse disorders;

(d) Small businesses and self-employed individuals;

(e) State Medicaid and CHIP agencies;

(f) Federally-recognized Tribes, as defined in the Federally Recognized Indian Tribe List Act of 1994, 25 U.S.C. 479a, that are located within such Exchange's geographic area;

(g) Public health experts;

(h) Health care providers;

(i) Large employers;

(j) Health insurance issuers; and

(k) Agents and brokers.

§ 155.140 Establishment of a regional Exchange or subsidiary Exchange.

(a) *Regional Exchange.* A State may participate in a regional Exchange if:

(1) The Exchange spans two or more States, regardless of whether the States are contiguous; and

(2) The regional Exchange submits a single Exchange Blueprint and is approved to operate consistent with § 155.105(c).

(b) *Subsidiary Exchange.* A State may establish one or more subsidiary Exchanges within the State if:

(1) Each such Exchange serves a geographically distinct area; and

(2) The area served by each subsidiary Exchange is at least as large as a rating area described in section 2701(a) of the PHS Act.

(c) *Exchange standards.* Each regional or subsidiary Exchange must:

(1) Otherwise meet the requirements of an Exchange consistent with this part; and

(2) Meet the following standards for SHOP:

(i) Perform the functions of a SHOP for its service area in accordance with subpart H of this part; and

(ii) Encompass the same geographic area for its regional or subsidiary SHOP and its regional or subsidiary Exchange except:

(A) In the case of a regional Exchange established pursuant to § 155.100(a)(2), the regional SHOP must encompass a geographic area that matches the combined geographic areas of the individual market Exchanges established to serve the same set of States establishing the regional SHOP; and

(B) In the case of a subsidiary Exchange established pursuant to § 155.100(a)(2), the combined geographic area of all subsidiary SHOPs established in the State must encompass the geographic area of the individual market Exchange established to serve the State.

§ 155.150 Transition process for existing State health insurance exchanges.

(a) *Presumption.* Unless an exchange is determined to be non-compliant through the process in paragraph (b) of this section, HHS will otherwise presume that an existing State exchange meets the standards under this part if:

(1) The exchange was in operation prior to January 1, 2010; and

(2) The State has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of the Affordable Care Act, according to the Congressional Budget Office estimates for projected coverage in 2016 that were published on March 30, 2011.

(b) *Process for determining noncompliance.* Any State described in paragraph (a) of this section must work with HHS to identify areas of noncompliance with the standards under this part.

§ 155.160 Financial support for continued operations.

(a) *Definition.* For purposes of this section, participating issuers has the meaning provided in § 156.50.

(b) *Funding for ongoing operations.* A State must ensure that its Exchange has sufficient funding in order to support its ongoing operations beginning January 1, 2015, as follows:

(1) States may generate funding, such as through user fees on participating issuers, for Exchange operations; and

(2) No Federal grants under section 1311 of the Affordable Care Act will be awarded for State Exchange establishment after January 1, 2015.

§ 155.170 Additional required benefits.

(a) *Additional required benefits.* (1) A State may require a QHP to offer benefits in addition to the essential health benefits.

(2) A benefit required by State action taking place on or before December 31, 2011 is considered an EHB. A benefit required by State action taking place on or after January 1, 2012, other than for purposes of compliance with Federal requirements, is considered in addition to the essential health benefits.

(3) The State will identify which State-required benefits are in addition to the EHB.

(b) *Payments.* The State must make payments to defray the cost of additional required benefits specified in paragraph (a) of this section to one of the following:

(1) To an enrollee, as defined in § 155.20 of this subchapter; or

(2) Directly to the QHP issuer on behalf of the individual described in paragraph (b)(1) of this section.

(c) *Cost of additional required benefits.* (1) Each QHP issuer in the State shall quantify cost attributable to each additional required benefit specified in paragraph (a) of this section.

(2) A QHP issuer's calculation shall be:

(i) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(ii) Conducted by a member of the American Academy of Actuaries; and

(iii) Reported to the State.

SUBPART C—GENERAL FUNCTIONS OF AN EXCHANGE

§ 155.200 Functions of an Exchange.

(a) *General requirements.* An Exchange must perform the functions described in this subpart and in subparts D, E, F, G, H, K, M, and O of this part unless the State is approved to operate only a SHOP by HHS under § 155.100(a)(2), in which case the Exchange operated by the State must perform the functions described in subpart H of this part and all applicable provisions of other subparts referenced in that subpart. In a State that is approved to operate only a SHOP, the individual market Exchange operated by HHS in that State will perform the functions described in this subpart and in subparts D, E, F, G, K, M, and O of this part.

(b) *Certificates of exemption.* The Exchange must issue certificates of exemption consistent with sections 1311(d)(4)(H) and 1411 of the Affordable Care Act.

(c) *Oversight and financial integrity.* The Exchange must perform required functions and cooperate with activities related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act and as required under this part, including overseeing its Exchange programs and non-Exchange entities as defined in § 155.260(b)(1).

(d) *Quality activities.* The Exchange must evaluate quality improvement strategies and oversee implementation of enrollee satisfaction surveys, assessment and ratings of health care quality and outcomes, information disclosures, and data reporting in accordance with sections 1311(c)(1), 1311(c)(3), and 1311(c)(4) of the Affordable Care Act.

(e) *Clarification.* In carrying out its responsibilities under this subpart, an Exchange is not operating on behalf of a QHP.

(f) *Requirements for State Exchanges on the Federal platform.* (1) A State that receives approval or conditional approval to operate a State Exchange on the Federal platform under § 155.106(c) may meet its obligations under paragraph (a) of this section by relying on Federal services that the Federal government agrees to provide under a Federal platform agreement.

(2) A State Exchange on the Federal platform must establish and oversee requirements for its issuers that are no less strict than the following requirements that are applied to Federally-facilitated Exchange issuers:

(i) Data submission requirements under § 156.122(d)(2) of this subchapter;

(ii) [Reserved]

(iii) [Reserved]

(iv) [Reserved]

(v) Changes of ownership of issuers requirements under § 156.330 of this subchapter;

(vi) QHP issuer compliance and compliance of delegated or downstream entities requirements under § 156.340(a)(4) of this subchapter; and

(vii) Casework requirements under § 156.1010 of this subchapter.

(3) If a State is not substantially enforcing any requirement listed under § 155.200(f)(2) with respect to a QHP issuer or plan in a State-based Exchange on the Federal platform, HHS may enforce that requirement directly against the issuer or plan by means of plan suppression under § 156.815 of this subchapter.

(4) A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, for plan years beginning on or after January 1, 2018, must require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under § 155.706(b)(6)(i)(A). A State Exchange on the Federal platform that utilizes the Federal platform for SHOP functions, as set forth in paragraphs (f)(4)(i) through (vii) of this section, for plan years beginning prior to January 1, 2018, must—

(i) If utilizing the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions, establish standard processes for premium calculation, premium payment, and premium collection that are consistent with the requirements applicable in a Federally-facilitated SHOP under § 155.705(b)(4);

(ii) If utilizing the Federal platform for SHOP enrollment or premium aggregation functions, require its QHP issuers to make any changes to rates in accordance with the timeline applicable in a Federally-facilitated SHOP under § 155.705(b)(6)(i)(A);

(iii) If utilizing the Federal platform for SHOP enrollment functions, establish minimum participation rate requirements and calculation methodologies that are consistent with those applicable in a Federally-facilitated SHOP under § 155.705(b)(10);

(iv) If utilizing the Federal platform for SHOP enrollment or premium aggregation functions, establish employer contribution methodologies that are consistent with the methodologies applicable in a Federally-facilitated SHOP under § 155.705(b)(11)(ii);

(v) If utilizing the Federal platform for SHOP enrollment functions, establish annual employee open enrollment period requirements that are consistent with § 155.725(e)(2);

(vi) If utilizing the Federal platform for SHOP enrollment functions, establish effective dates of coverage for an initial group enrollment or a group renewal that are consistent with the effective dates of coverage applicable in a Federally-facilitated SHOP under § 155.725(h)(2); and

(vii) If utilizing the Federal platform for SHOP eligibility, enrollment, or premium aggregation functions, establish policies for the termination of SHOP coverage or enrollment that are consistent with the requirements applicable in a Federally-facilitated SHOP under § 155.735.

§ 155.205 Consumer assistance tools and programs of an Exchange.

(a) *Call center.* The Exchange must provide for operation of a toll-free call center that addresses the needs of consumers requesting assistance and meets the requirements outlined in paragraphs (c)(1), (2)(i), and (3) of this section, unless it is an Exchange described in paragraphs (a)(1) or (2) of this section, in which case, the Exchange must provide at a minimum a toll-free telephone hotline that includes the capability to provide information to consumers about eligibility and enrollment processes, and to appropriately direct consumers to the applicable Exchange website and other applicable resources.

(1) An Exchange described in this paragraph is one that enters into a Federal platform agreement through which it relies on HHS to operate its eligibility and enrollment functions, as applicable.

(2) An Exchange described in this paragraph is a SHOP that does not provide for enrollment in SHOP coverage through an online SHOP enrollment platform, but rather provides for enrollment through SHOP issuers or agents and brokers registered with the Exchange.

(b) *Internet Web site.* The Exchange must maintain an up-to-date Internet Web site that meets the requirements outlined in paragraph (c) of this section and:

(1) Provides standardized comparative information on each available QHP, which may include differential display of standardized options on consumer-facing plan comparison and shopping tools, and at a minimum includes:

(i) Premium and cost-sharing information;

(ii) The summary of benefits and coverage established under section 2715 of the PHS Act;

(iii) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(iv) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(v) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act;

(vi) Medical loss ratio information as reported to HHS in accordance with 45 CFR part 158;

(vii) Transparency of coverage measures reported to the Exchange during certification in accordance with § 155.1040; and

(viii) The provider directory made available to the Exchange in accordance with § 156.230.

(2) Publishes the following financial information:

(i) The average costs of licensing required by the Exchange;

(ii) Any regulatory fees required by the Exchange;

(iii) Any payments required by the Exchange in addition to fees under paragraphs (b)(2)(i) and (ii) of this section;

(iv) Administrative costs of such Exchange; and

(v) Monies lost to waste, fraud, and abuse.

(3) Provides applicants with information about Navigators as described in § 155.210 and other consumer assistance services, including the toll-free telephone number of the Exchange call center required in paragraph (a) of this section.

(4) Allows for an eligibility determination to be made in accordance with subpart D of this part.

(5) Allows a qualified individual to select a QHP in accordance with subpart E of this part.

(6) Makes available by electronic means a calculator to facilitate the comparison of available QHPs after the application of any advance payments of the premium tax credit and any cost-sharing reductions.

(7) A State-based Exchange on the Federal platform must at a minimum maintain an informational Internet Web site that includes the capability to direct consumers to Federal platform services to apply for, and enroll in, Exchange coverage.

(c) *Accessibility.* Information must be provided to applicants and enrollees in plain language and in a manner that is accessible and timely to—

(1) Individuals living with disabilities including accessible Web sites and the provision of auxiliary aids and services at no cost to the individual in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act.

(2) Individuals who are limited English proficient through the provision of language services at no cost to the individual, including

(i) For all entities subject to this standard, oral interpretation.

(A) For Exchanges and QHP issuers, this standard also includes telephonic interpreter services in at least 150 languages.

(B) For a web-broker, beginning November 1, 2015, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, this standard also includes telephonic interpreter services in at least 150 languages.

(ii) Written translations; and

(iii) For all entities subject to this standard, taglines in non-English languages indicating the availability of language services.

(A) For Exchanges and QHP issuers, this standard also includes taglines on Web site content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. A document is deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if it is required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. If an Exchange is operated by an entity that operates multiple Exchanges, or if an Exchange relies on an entity to conduct its eligibility or enrollment functions and that entity conducts such functions for multiple Exchanges, the Exchange may aggregate the limited English proficient populations across all the States served by the entity that operates the Exchange or conducts its eligibility or enrollment functions to determine the top 15 languages required for taglines. A QHP issuer may aggregate the limited English proficient populations across all States served by the health insurance issuers within the issuer's controlled group (defined for purposes of this section as a group of two or more persons that is treated as a single employer under sections 52(a), 52(b), 414(m), or 414(o) of the Internal Revenue Code of 1986, as amended), whether or not those health insurance issuers offer plans through the Exchange in each of those States, to determine the top 15 languages required for taglines. Exchanges and QHP issuers may satisfy tagline requirements with respect to Web site content if they post a Web link prominently on their home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if they also include taglines on any critical standalone document linked to or embedded in the Web site. Exchanges, and QHP issuers that are also subject to § 92.8 of this subtitle, will be deemed in compliance with paragraph (c)(2)(iii)(A) of this section if they are in compliance with § 92.8 of this subtitle.

(B) For a web-broker, beginning when such entity has been registered with the Exchange for at least 1 year, this standard also includes taglines on website content and any document that is critical for obtaining health insurance coverage or access to health care services through a QHP for qualified individuals, applicants, qualified employers, qualified employees, or enrollees. Website content or documents are deemed to be critical for obtaining health insurance coverage or access to health care services through a QHP if they are required to be provided by law or regulation to a qualified individual, applicant, qualified employer, qualified employee, or enrollee. Such taglines must indicate the availability of language services in at least the top 15 languages spoken by the limited English proficient population of the relevant State or States, as determined in guidance published by the Secretary. A web-broker that is licensed in and serving multiple States may aggregate the limited English populations in the States it serves to determine the top 15 languages required for taglines. A web-broker may satisfy tagline requirements with respect to website content if it posts a Web link prominently on its home page that directs individuals to the full text of the taglines indicating how individuals may obtain language assistance services, and if it also includes taglines on any critical standalone document linked to or embedded in the website.

(iv) For Exchanges, QHP issuers, and web-brokers, website translations.

(A) For an Exchange, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, content that is intended for qualified individuals, applicants, qualified employers, qualified employees, or enrollees on a Web site that is maintained by the Exchange must be translated into any non-English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(B) For a QHP issuer, beginning no later than the first day of the individual market open enrollment period for the 2017 benefit year, if the content of a Web site maintained by the QHP issuer is critical for obtaining health insurance coverage or access to health care services through a QHP, within the meaning of § 156.250 of this subchapter, it must be translated into any non- English language that is spoken by a limited English proficient population that reaches 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(C) For a web-broker, beginning on the first day of the individual market open enrollment period for the 2017 benefit year, or when such entity has been registered with the Exchange for at least 1 year, whichever is later, content that is intended for qualified individuals, applicants, qualified employers, qualified employees, or enrollees on a website that is maintained by the web-broker must be translated into any non- English language that is spoken by a limited English proficient population that comprises 10 percent or more of the population of the relevant State, as determined in guidance published by the Secretary.

(3) Inform individuals of the availability of the services described in paragraphs (c)(1) and (2) of this section and how to access such services.

(d) *Consumer assistance.* (1) The Exchange must have a consumer assistance function that meets the standards in paragraph (c) of this section, including the Navigator program described in § 155.210. Any individual providing such consumer assistance must be trained regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the State, as implemented in the State, prior to providing such assistance or the outreach and education activities specified in paragraph (e) of this section.

(2) The Exchange must provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the Public Health Service Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage.

(e) *Outreach and education.* The Exchange must conduct outreach and education activities that meet the standards in paragraph (c) of this section to educate consumers about the Exchange and insurance affordability programs to encourage participation.

§ 155.206 Civil money penalties for violations of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges.

(a) *Enforcement actions.* If an individual or entity specified in paragraph (b) of this section engages in activity specified in paragraph (c) of this section, the Department of Health and Human Services (HHS) may impose the following sanctions:

(1) Civil money penalties (CMPs), subject to the provisions of this section.

(2) Corrective action plans. In the notice of assessment of CMPs specified in paragraph (l) of this section, HHS may provide an individual or entity specified in paragraph (b) of this section the opportunity to enter into a corrective action plan to correct the violation instead of paying the CMP, based on evaluation of the factors set forth in paragraph (h) of this section. In the event that the individual or entity does not follow such a

corrective action plan, HHS could require payment of the CMP.

(b) *Consumer assistance entities.* CMPs may be assessed under this section against the following consumer assistance entities:

(1) Individual Navigators and Navigator entities in a Federally-facilitated Exchange, including grantees, sub-grantees, and all personnel carrying out Navigator duties on behalf of a grantee or sub-grantee;

(2) Non-Navigator assistance personnel authorized under § 155.205(d) and (e) and non-Navigator assistance personnel entities in a Federally-facilitated Exchange, including but not limited to individuals and entities under contract with HHS to facilitate consumer enrollment in QHPs in a Federally-facilitated Exchange; and

(3) Organizations that a Federally-facilitated Exchange has designated as certified application counselor organizations and individual certified application counselors carrying out certified application counselor duties in a Federally-facilitated Exchange.

(c) *Grounds for assessing CMPs.* HHS may assess CMPs against a consumer assistance entity if, based on the outcome of the investigative process outlined in paragraphs (d) through (i) of this section, HHS has reasonably determined that the consumer assistance entity has failed to comply with the Federal regulatory requirements applicable to the consumer assistance entity that have been implemented pursuant to section 1321(a)(1) of the Affordable Care Act, including provisions of any agreements, contracts, and grant terms and conditions between HHS and the consumer assistance entity that interpret those Federal regulatory requirements or establish procedures for compliance with them, unless a CMP has been assessed for the same conduct under 45 CFR 155.285.

(d) *Basis for initiating an investigation of a potential violation.* (1) *Information.* Any information received or learned by HHS that indicates that a consumer assistance entity may have engaged or may be engaging in activity specified in paragraph (c) of this section may warrant an investigation. Information that might trigger an investigation includes, but is not limited to, the following:

(i) Complaints from the general public;

(ii) Reports from State regulatory agencies, and other Federal and State agencies; or

(iii) Any other information that indicates that a consumer assistance entity may have engaged or may be engaging in activity specified in paragraph (c) of this section.

(2) *Who may file a complaint.* Any entity or individual, or the legally authorized representative of an entity or individual, may file a complaint with HHS alleging that a consumer assistance entity has engaged or is engaging in an activity specified in paragraph (c) of this section.

(e) *Notice of investigation.* When HHS performs an investigation under this section, it must provide a written notice to the consumer assistance entity of its investigation. This notice must include the following:

(1) Description of the activity that is being investigated.

(2) Explanation that the consumer assistance entity has 30 days from the date of the notice to respond with additional information or documentation, including information or documentation to refute an alleged violation.

(3) State that a CMP might be assessed if the allegations are not, as determined by HHS, refuted within 30 days from the date of the notice.

(f) *Request for extension.* In circumstances in which a consumer assistance entity cannot prepare a response to HHS within the 30 days provided in the notice of investigation described in paragraph (e) of this section, the entity may make a written request for an extension from HHS detailing the reason for the extension request and showing good cause. If HHS grants the extension, the consumer assistance entity must respond to the notice within the time frame specified in HHS's letter granting the extension of time. Failure to respond within 30 days, or, if applicable, within an extended time frame, may result in HHS's imposition of a CMP depending upon the outcome of HHS's investigation of the alleged violation.

(g) *Responses to allegations of noncompliance.* In determining whether to impose a CMP, HHS may

review and consider documents or information received or collected in accordance with paragraph (d)(1) of this section, as well as additional documents or information provided by the consumer assistance entity in response to receiving a notice of investigation in accordance with paragraph (e)(2) of this section. HHS may also conduct an independent investigation into the alleged violation, which may include site visits and interviews, if applicable, and may consider the results of this investigation in its determination.

(h) *Factors in determining noncompliance and amount of CMPs, if any.* In determining whether there has been noncompliance by the consumer assistance entity, and whether CMPs are appropriate:

(1) HHS must take into account the following:

(i) The consumer assistance entity's previous or ongoing record of compliance, including but not limited to compliance or noncompliance with any corrective action plan.

(ii) The gravity of the violation, which may be determined in part by—

(A) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread; and

(B) Whether the violation caused, or could reasonably be expected to cause, financial or other adverse impacts on consumer(s), and the magnitude of those impacts;

(2) HHS may take into account the following:

(i) The degree of culpability of the consumer assistance entity, including but not limited to—

(A) Whether the violation was beyond the direct control of the consumer assistance entity; and

(B) The extent to which the consumer assistance entity received compensation—legal or otherwise—for the services associated with the violation;

(ii) Aggravating or mitigating circumstances;

(iii) Whether other remedies or penalties have been assessed and/or imposed for the same conduct or occurrence; or

(iv) Other such factors as justice may require.

(i) *Maximum per-day penalty.* The maximum amount of penalty imposed for each violation is $100 for each day, as adjusted annually under 45 CFR part 102, for each consumer assistance entity for each individual directly affected by the consumer assistance entity's noncompliance; and where the number of individuals cannot be determined, HHS may reasonably estimate the number of individuals directly affected by the violation.

(j) *Settlement authority.* Nothing in § 155.206 limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with paragraph (e) of this section or to compromise on any penalty provided for in this section.

(k) *Limitations on penalties.* (1) *Circumstances under which a CMP is not imposed.* HHS will not impose any CMP on:

(i) Any violation for the period of time during which none of the consumer assistance entities knew, or exercising reasonable diligence would have known, of the violation; or

(ii) The period of time after any of the consumer assistance entities knew, or exercising reasonable diligence would have known, of the failure, if the violation was due to reasonable cause and not due to willful neglect and the violation was corrected within 30 days of the first day that any of the consumer assistance entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the violation existed.

(2) *Burden of establishing knowledge.* The burden is on the consumer assistance entity or entities to establish to HHS's satisfaction that the consumer assistance entity did not know, or exercising reasonable diligence would have known, that the violation existed, as well as the period of time during which that limitation applies; or that the violation was due to reasonable cause and not due

to willful neglect and was corrected pursuant to the elements in paragraph (k)(1)(ii) of this section.

(3) *Time limit for commencing action.* No action under this section will be entertained unless commenced, in accordance with § 155.206(l), within six years from the date on which the violation occurred.

(l) *Notice of assessment of CMP.* If HHS proposes to assess a CMP in accordance with this section, HHS will send a written notice of this decision to the consumer assistance entity against whom the sanction is being imposed, which notice must include the following:

(1) A description of the basis for the determination;

(2) The basis for the CMP;

(3) The amount of the CMP, if applicable;

(4) The date the CMP, if applicable, is due;

(5) Whether HHS would permit the consumer assistance entity to enter into a corrective action plan in place of paying the CMP, and the terms of any such corrective action plan;

(6) An explanation of the consumer assistance entity's right to a hearing under paragraph (m) of this section; and

(7) Information about the process for filing a request for a hearing.

(m) *Appeal of proposed sanction.* Any consumer assistance entity against which HHS has assessed a sanction may appeal that penalty in accordance with the procedures set forth at 45 CFR part 150, subpart D.

(n) *Failure to request a hearing.* (1) If the consumer assistance entity does not request a hearing within 30 days of the issuance of the notice of assessment of CMP described in paragraph (l) of this section, HHS may require payment of the proposed CMP.

(2) HHS will notify the consumer assistance entity in writing of any CMP that has been assessed and of the means by which the consumer assistance entity may pay the CMP.

(3) The consumer assistance entity has no right to appeal a CMP with respect to which it has not requested a hearing in accordance with paragraph (m) of this section unless the consumer assistance entity can show good cause in accordance with § 150.405(b) of this subchapter for failing to timely exercise its right to a hearing.

§ 155.210 Navigator program standards.

(a) *General Requirements.* The Exchange must establish a Navigator program consistent with this section through which it awards grants to eligible public or private entities or individuals described in paragraph (c) of this section.

(b) *Standards.* The Exchange must develop and publicly disseminate—

(1) A set of standards, to be met by all entities and individuals to be awarded Navigator grants, designed to prevent, minimize and mitigate any conflicts of interest, financial or otherwise, that may exist for an entity or individuals to be awarded a Navigator grant and to ensure that all entities and individuals carrying out Navigator functions have appropriate integrity; and

(2) A set of training standards, to be met by all entities and individuals carrying out Navigator functions under the terms of a Navigator grant, to ensure the entities and individuals are qualified to engage in Navigator activities, including training standards on the following topics:

(i) The needs of underserved and vulnerable populations;

(ii) Eligibility and enrollment rules and procedures;

(iii) The range of QHP options and insurance affordability programs; and

(iv) The privacy and security standards applicable under § 155.260.

(c) *Entities and individuals eligible to be a Navigator.* (1) To receive a Navigator grant, an entity or individual must—

(i) Be capable of carrying out at least those duties described in paragraph (e) of this section;

(ii) Demonstrate to the Exchange that the entity has existing relationships, or could readily establish relationships, with employers and employees, consumers (including uninsured and underinsured consumers), or self-employed individuals likely to be eligible for enrollment in a QHP;

(iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not limited to the following:

(A) Except as otherwise provided under § 155.705(d), requirements that Navigators refer consumers to other entities not required to provide fair, accurate, and impartial information.

(B) Except as otherwise provided under § 155.705(d), requirements that would prevent Navigators from providing services to all persons to whom they are required to provide assistance.

(C) Requirements that would prevent Navigators from providing advice regarding substantive benefits or comparative benefits of different health plans.

(D) Requiring that a Navigator hold an agent or broker license or imposing any requirement that, in effect, would require all Navigators in the Exchange to be licensed agents or brokers.

(E) Imposing standards that would, as applied or as implemented in a State, prevent the application of Federal requirements applicable to Navigator entities or individuals or applicable to the Exchange's implementation of the Navigator program.

(iv) Not have a conflict of interest during the term as Navigator; and,

(v) Comply with the privacy and security standards adopted by the Exchange as required in accordance with § 155.260.

(2) The Exchange must include an entity from at least one of the following categories for receipt of a Navigator grant:

(i) Community and consumer-focused nonprofit groups;

(ii) Trade, industry, and professional associations;

(iii) Commercial fishing industry organizations, ranching and farming organizations;

(iv) Chambers of commerce;

(v) Unions;

(vi) Resource partners of the Small Business Administration;

(vii) Licensed agents and brokers; and

(viii) Other public or private entities or individuals that meet the requirements of this section. Other entities may include but are not limited to Indian tribes, tribal organizations, urban Indian organizations, and State or local human service agencies.

(d) *Prohibition on Navigator conduct.* The Exchange must ensure that a Navigator must not—

(1) Be a health insurance issuer or issuer of stop loss insurance;

(2) Be a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(3) Be an association that includes members of, or lobbies on behalf of, the insurance industry;

(4) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with

the enrollment of any individuals or employees in a QHP or a non-QHP. Notwithstanding the requirements of this paragraph (d)(4), in a Federally-facilitated Exchange, no health care provider shall be ineligible to operate as a Navigator solely because it receives consideration from a health insurance issuer for health care services provided;

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties;

(6) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (d)(6), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses;

(7) Use Exchange funds to purchase gifts or gift cards, or promotional items that market or promote the products or services of a third party, that would be provided to any applicant or potential enrollee; or

(8) [Reserved]

(9) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual Navigator or Navigator entity has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

(e) *Duties of a Navigator*. An entity that serves as a Navigator must carry out at least the following duties:

(1) Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise awareness about the Exchange;

(2) Provide information and services in a fair, accurate, and impartial manner, which includes: providing information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process. Such information must acknowledge other health programs;

(3) Facilitate selection of a QHP;

(4) Provide referrals to any applicable office of health insurance consumer assistance or health insurance ombudsman established under section 2793 of the PHS Act, or any other appropriate State agency or agencies, for any enrollee with a grievance, complaint, or question regarding their health plan, coverage, or a determination under such plan or coverage;

(5) Provide information in a manner that is culturally and linguistically appropriate to the needs of the population being served by the Exchange, including individuals with limited English proficiency, and ensure accessibility and usability of Navigator tools and functions for individuals with disabilities in accordance with the Americans with Disabilities Act and section 504 of the Rehabilitation Act;

(6) Ensure that applicants—

(i) Are informed, prior to receiving assistance, of the functions and responsibilities of Navigators, including that Navigators are not acting as tax advisers or attorneys when providing assistance as Navigators and cannot provide tax or legal advice within their capacity as Navigators;

(ii) Provide authorization in a form and manner as determined by the Exchange prior to a Navigator's obtaining access to an applicant's personally identifiable information, and that the Navigator maintains a record of the authorization provided in a form and manner as determined by the

Exchange. The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is no less than six years, unless a different and longer retention period has already been provided under other applicable Federal law; and

(iii) May revoke at any time the authorization provided the Navigator pursuant to paragraph (e)(6)(ii) of this section; and [*sic*]

(7) In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a Navigator solely because its principal place of business is outside of the Exchange service area;

(8) Provide targeted assistance to serve underserved or vulnerable populations, as identified by the Exchange, within the Exchange service area.

(i) In a Federally-facilitated Exchange, this paragraph (e)(8) will apply beginning with the Navigator grant application process for Navigator grants awarded in 2018. The Federally-facilitated Exchange will identify populations as vulnerable or underserved that are disproportionately without access to coverage or care, or that are at a greater risk for poor health outcomes, in the funding opportunity announcement for its Navigator grants, and applicants for those grants will have an opportunity to propose additional vulnerable or underserved populations in their applications for the Federally-facilitated Exchange's approval.

(ii) [Reserved]

(9) The Exchange may require or authorize Navigators to provide information and assistance with any of the following topics. In federally-facilitated Exchanges, FY 2021 Navigator grantees will be required to perform these duties beginning with the Navigator grant funding awarded in FY 2022 for the second 12-month budget period of the 36-month period of performance. Beginning with Navigator grants awarded in 2022, including noncompeting continuation awards, Navigators are required to provide information and assistance with all of the following topics:

(i) Understanding the process of filing Exchange eligibility appeals;

(ii) Understanding and applying for exemptions from the requirement to maintain minimum essential coverage granted through the Exchange;

(iii) The Exchange-related components of the premium tax credit reconciliation process, and understanding the availability of IRS resources on this process;

(iv) Understanding basic concepts and rights related to health coverage and how to use it; and

(v) Referrals to licensed tax advisers, tax preparers, or other resources for assistance with tax preparation and tax advice related to consumer questions about the Exchange application and enrollment process, and premium tax credit reconciliations.

(f) *Funding for Navigator grants.* Funding for Navigator grants may not be from Federal funds received by the State to establish the Exchange.

§ 155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.

(a) *Conflict-of-interest standards.* The following conflict-of-interest standards apply in an Exchange operated by HHS during the exercise of its authority under § 155.105(f) and to non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act:

(1) *Conflict-of-interest standards for Navigators.* (i) All Navigator entities, including Navigator grant applicants, must submit to the Exchange a written attestation that the Navigator, including the Navigator's staff:

(A) Is not a health insurance issuer or issuer of stop loss insurance;

(B) Is not a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(C) Is not an association that includes members of, or lobbies on behalf of, the insurance industry; and

(D) Will not receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or non-QHP.

(ii) All Navigator entities must submit to the Exchange a written plan to remain free of conflicts of interest during the term as a Navigator.

(iii) All Navigator entities, including the Navigator's staff, must provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible.

(iv) All Navigator entities, including the Navigator's staff, must disclose to the Exchange and, in plain language, to each consumer who receives application assistance from the Navigator:

(A) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in § 155.210(d), which the Navigator intends to sell while carrying out the consumer assistance functions;

(B) Any existing employment relationships, or any former employment relationships within the last 5 years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(C) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(2) Conflict-of-interest standards for Non-Navigator assistance personnel carrying out consumer assistance functions under § 155.205(d) and (e). All Non-Navigator entities or individuals authorized to carry out consumer assistance functions under § 155.205(d) and (e) must—

(i) Comply with the prohibitions on Navigator conduct set forth at § 155.210(d) and the duties of a Navigator set forth at § 155.210(e)(2).

(ii) Submit to the Exchange a written attestation that the entity or individual—

(A) Is not a health insurance issuer or issuer of stop loss insurance;

(B) Is not a subsidiary of a health insurance issuer or issuer of stop loss insurance;

(C) Is not an association that includes members of, or lobbies on behalf of, the insurance industry; and

(D) Will not receive any consideration directly or indirectly from any health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any individuals or employees in a QHP or non-QHP.

(iii) Submit to the Exchange a written plan to remain free of conflicts of interest while carrying out consumer assistance functions under § 155.205(d) and (e).

(iv) Provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible.

(v) Submit to the Exchange, and, in plain language, to each consumer who receives application assistance from the entity or individual:

(A) Any lines of insurance business, not covered by the restrictions on participation and prohibitions on conduct in § 155.210(d), which the entity or individual intends to sell while carrying out the consumer assistance functions;

(B) Any existing employment relationships, or any former employment relationships within the last five years, with any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance, including any existing employment relationships between a spouse or domestic partner and any health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance; and

(C) Any existing or anticipated financial, business, or contractual relationships with one or more health insurance issuers or issuers of stop loss insurance, or subsidiaries of health insurance issuers or issuers of stop loss insurance.

(b) *Training standards for Navigators and Non-Navigator assistance personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210.* The following training standards apply in an Exchange operated by HHS during the exercise of its authority under § 155.105(f), and to non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act.

(1) Certification and recertification standards. All individuals or entities who carry out consumer assistance functions under §§ 155.205(d) and (e) and 155.210, including Navigators, must meet the following certification and recertification requirements.

(i) Obtain certification by the Exchange prior to carrying out any consumer assistance functions or outreach and education activities under §§ 155.205(d) and (e) or 155.210;

(ii) Register for and complete a HHS-approved training;

(iii) Following completion of the HHS-approved training described in paragraph (b)(1)(ii) of this section, complete and achieve a passing score on all approved certification examinations prior to carrying out any consumer assistance functions under §§ 155.205(d) and (e) or 155.210;

(iv) Obtain continuing education and be certified and/or recertified on at least an annual basis; and

(v) Be prepared to serve both the individual Exchange and SHOP.

(2) *Training module content standards.* All individuals who carry out the consumer assistance functions under §§ 155.205(d) and (e) and 155.210 must receive training consistent with standards established by the Exchange consistent with § 155.210(b)(2).

(i) QHPs (including the metal levels described at § 156.140(b) of this subchapter), and how they operate, including benefits covered, payment processes, rights and processes for appeals and grievances, and contacting individual plans;

(ii) The range of insurance affordability programs, including Medicaid, the Children's Health Insurance Program (CHIP), and other public programs;

(iii) The tax implications of enrollment decisions;

(iv) Eligibility requirements for premium tax credits and cost-sharing reductions, and the impacts of premium tax credits on the cost of premiums;

(v) Contact information for appropriate federal, state, and local agencies for consumers seeking additional information about specific coverage options not offered through the Exchange;

(vi) Basic concepts about health insurance and the Exchange; the benefits of having health insurance and enrolling through an Exchange; and the individual responsibility to have health insurance;

(vii) Eligibility and enrollment rules and procedures, including how to appeal an eligibility determination;

(viii) Providing culturally and linguistically appropriate services;

(ix) Ensuring physical and other accessibility for people with a full range of disabilities;

(x) Understanding differences among health plans;

(xi) Privacy and security standards applicable under § 155.260 for handling and safeguarding consumers' personally identifiable information;

(xii) Working effectively with individuals with limited English proficiency, people with a full range of disabilities, and vulnerable, rural, and underserved populations;

(xiii) Customer service standards;

(xiv) Outreach and education methods and strategies; and

(xv) Applicable administrative rules, processes and systems related to Exchanges and QHPs.

(c) *Providing Culturally and Linguistically Appropriate Services (CLAS Standards).* The following standards will apply in an Exchange operated by HHS during the exercise of its authority under § 155.105(f) and to non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act. To ensure that information provided as part of any consumer assistance functions under §§ 155.205(d) and (e) or 155.210 is culturally and linguistically appropriate to the needs of the population being served, including individuals with limited English proficiency as required by §§ 155.205(c)(2) and 155.210(e)(5), any entity or individual carrying out these functions must:

(1) Develop and maintain general knowledge about the racial, ethnic, and cultural groups in their service area, including each group's diverse cultural health beliefs and practices, preferred languages, health literacy, and other needs;

(2) Collect and maintain updated information to help understand the composition of the communities in the service area, including the primary languages spoken;

(3) Provide consumers with information and assistance in the consumer's preferred language, at no cost to the consumer, including the provision of oral interpretation of non- English languages and the translation of written documents in non-English languages when necessary or when requested by the consumer to ensure effective communication. Use of a consumer's family or friends as oral interpreters can satisfy the requirement to provide linguistically appropriate services only when requested by the consumer as the preferred alternative to an offer of other interpretive services;

(4) Provide oral and written notice to consumers with limited English proficiency, in their preferred language, informing them of their right to receive language assistance services and how to obtain them;

(5) Receive ongoing education and training in culturally and linguistically appropriate service delivery; and

(6) Implement strategies to recruit, support, and promote a staff that is representative of the demographic characteristics, including primary languages spoken, of the communities in their service area.

(d) *Standards ensuring access by persons with disabilities.* The following standards related to ensuring access by people with disabilities will apply in an Exchange operated by HHS during the exercise of its authority under § 155.105(f), and to non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act. Any entity or individual carrying out any consumer assistance functions under §§ 155.205(d) and (e) or 155.210, and in accordance with § 155.205(c), must—

(1) Ensure that any consumer education materials, Web sites, or other tools utilized for consumer assistance purposes, are accessible to people with disabilities, including those with sensory impairments, such as visual or hearing impairments, and those with mental illness, addiction, and physical, intellectual, and developmental disabilities;

(2) Provide auxiliary aids and services for individuals with disabilities, at no cost, when necessary or when requested by the consumer to ensure effective communication. Use of a consumer's family or friends as interpreters can satisfy the requirement to provide auxiliary aids and services only when requested by the consumer as the preferred alternative to an offer of other auxiliary aids and services;

(3) Provide assistance to consumers in a location and in a manner that is physically and otherwise accessible to individuals with disabilities;

(4) Ensure that authorized representatives are permitted to assist an individual with a disability to make informed decisions;

(5) Acquire sufficient knowledge to refer people with disabilities to local, state, and federal long-term services and supports programs when appropriate; and

(6) Be able to work with all individuals regardless of age, disability, or culture, and seek advice or experts when needed.

(e) *Monitoring.* Any Exchange operated by HHS during the exercise of its authority under § 155.105(f) will monitor compliance with the standards in this section and the requirements of §§ 155.205(d) and (e) and 155.210.

(f) *State or Exchange standards.* All non-Navigator entities or individuals carrying out consumer assistance functions under § 155.205(d) and (e) in an Exchange operated by HHS during the exercise of its authority under § 155.105(f) and all non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act must meet any licensing, certification, or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not limited to the following:

(1) Requirements that non-Navigator entities or individuals refer consumers to other entities not required to provide fair, accurate, and impartial information.

(2) Requirements that would prevent non-Navigator entities or individuals from providing services to all persons to whom they are required to provide assistance.

(3) Requirements that would prevent non-Navigator entities or individuals from providing advice regarding substantive benefits or comparative benefits of different health plans.

(4) Imposing standards that would, as applied or as implemented in a State, prevent the application of Federal requirements applicable to non-Navigator entities or individuals or applicable to the Exchange's implementation of the non-Navigator assistance personnel program.

(g) *Consumer authorization.* All non-Navigator entities or individuals carrying out consumer assistance functions under § 155.205(d) and (e) in an Exchange operated by HHS during the exercise of its authority under § 155.105(f) and all non-Navigator assistance personnel funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act must establish procedures to ensure that applicants—

(1) Are informed, prior to receiving assistance, of the functions and responsibilities of non-Navigator assistance personnel, including that non-Navigator assistance personnel are not acting as tax advisers or attorneys when providing assistance as non- Navigator assistance personnel and cannot provide tax or legal advice within their capacity as non-Navigator assistance personnel;

(2) Provide authorization in a form and manner as determined by the Exchange prior to a non-Navigator assistance personnel's obtaining access to an applicant's personally identifiable information, and that the non-Navigator assistance personnel maintains a record of the authorization provided in a form and manner as

determined by the Exchange. The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is no less than six years, unless a different and longer retention period has already been provided under other applicable Federal law; and

(3) May revoke at any time the authorization provided the non- Navigator assistance personnel pursuant to paragraph (g)(2) of this section.

(h) *Physical presence.* In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a non-Navigator entity or as non-Navigator assistance personnel solely because its principal place of business is outside of the Exchange service area.

(i) *Prohibition on compensation per enrollment.* Beginning November 15, 2014, Navigators and Non-Navigator assistance personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210, if operating in an Exchange operated by HHS during the exercise of its authority under § 155.105(f), are prohibited from providing compensation to individual Navigators or non-Navigator assistance personnel on a per-application, per-individual- assisted, or per-enrollment basis.

§ 155.220 Ability of States to permit agents and brokers and web-brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs.

(a) *General rule.* A State may permit agents, brokers, and web-brokers to—

(1) Enroll individuals, employers or employees in any QHP in the individual or small group market as soon as the QHP is offered through an Exchange in the State;

(2) Subject to paragraphs (c), (d), and (e) of this section, enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and

(3) Subject to paragraphs (d) and (e) of this section, assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

(b)(1) *Web site disclosure.* The Exchange or SHOP may elect to provide information regarding licensed agents and brokers on its Web site for the convenience of consumers seeking insurance through that Exchange and may elect to limit the information to information regarding licensed agents and brokers who have completed any required Exchange or SHOP registration and training process.

(2) A Federally-facilitated Exchange or SHOP will limit the information provided on its Web site regarding licensed agents and brokers to information regarding licensed agents and brokers who have completed registration and training.

(c) *Enrollment through the Exchange.* A qualified individual may be enrolled in a QHP through the Exchange with the assistance of an agent, broker, or web-broker if—

(1) The agent, broker, or web-broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange internet website as described in § 155.405, or ensures that the eligibility application information is submitted for an eligibility determination through the Exchange-approved web service subject to meeting the requirements in paragraphs (c)(3)(ii) and (c)(4)(i)(F) of this section;

(2) The Exchange transmits enrollment information to the QHP issuer as provided in § 155.400(a) to allow the issuer to effectuate enrollment of qualified individuals in the QHP.

(3)(i) When an internet website of a web-broker is used to complete the QHP selection, at a minimum the internet website must:

(A) Disclose and display the following QHP information provided by the Exchange or directly by QHP issuers consistent with the requirements of § 155.205(c), and to the extent that enrollment support for a QHP is not available using the web-broker's website, prominently display a standardized disclaimer provided by HHS stating that enrollment support for the QHP is available on the Exchange website, and provide a Web link to the Exchange website:

(*1*) Premium and cost-sharing information;

(*2*) The summary of benefits and coverage established under section 2715 of the PHS Act;

(*3*) Identification of whether the QHP is a bronze, silver, gold, or platinum level plan as defined by section 1302(d) of the Affordable Care Act, or a catastrophic plan as defined by section 1302(e) of the Affordable Care Act;

(*4*) The results of the enrollee satisfaction survey, as described in section 1311(c)(4) of the Affordable Care Act;

(*5*) Quality ratings assigned in accordance with section 1311(c)(3) of the Affordable Care Act; and

(*6*) The provider directory made available to the Exchange in accordance with § 156.230 of this subchapter.

(B) Provide consumers the ability to view all QHPs offered through the Exchange;

(C) Not provide financial incentives, such as rebates or giveaways;

(D) Display all QHP data provided by the Exchange;

(E) Maintain audit trails and records in an electronic format for a minimum of ten years and cooperate with any audit under this section;

(F) Provide consumers with the ability to withdraw from the process and use the Exchange Web site described in § 155.205(b) instead at any time;

(G) For the Federally-facilitated Exchange, prominently display a standardized disclaimer provided by HHS, and provide a Web link to the Exchange Web site;

(H) Differentially display all standardized options prominently and in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the Federally-facilitated Exchange Web site and with standards defined by HHS, unless HHS approves a deviation;

(I) Prominently display information provided by HHS pertaining to a consumer's eligibility for advance payments of the premium tax credit or cost-sharing reductions;

(J) Allow the consumer to select an amount for advance payments of the premium tax credit, if applicable, and make related attestations in accordance with § 155.310(d)(2);

(K) Comply with the applicable requirements in § 155.221; and

(L) Not display QHP advertisements or recommendations, or otherwise provide favored or preferred placement in the display of QHPs, based on compensation the agent, broker, or web-broker receives from QHP issuers; and

(M) Prominently display a clear explanation of the rationale for QHP recommendations and the methodology for its default display of QHPs.

(ii) When an internet website of a web-broker is used to complete the Exchange eligibility application, at a minimum the internet website must:

(A) Comply with the requirements in paragraph (c)(3)(i) of this section;

(B) Use exactly the same eligibility application language as appears in the FFE Single Streamlined Application required in § 155.405, unless HHS approves a deviation;

(C) Ensure that all necessary information for the consumer's applicable eligibility

circumstances are submitted through the Exchange-approved web service; and

(D) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§ 155.230 and 155.260(b).

(4) When an agent or broker, through a contract or other arrangement, uses the internet website of a web-broker to help an applicant or enrollee complete a QHP selection or complete the Exchange eligibility application in the Federally-facilitated Exchange:

(i) The web-broker who makes the website available must:

(A) Provide HHS with a list of agents and brokers who enter into such a contract or other arrangement to use the web-broker's website, in a form and manner to be specified by HHS;

(B) Verify that any agent or broker accessing or using the Web site pursuant to the arrangement is licensed in the State in which the consumer is selecting the QHP; and has completed training and registration and has signed all required agreements with the Federally-facilitated Exchange pursuant to paragraph (d) of this section and § 155.260(b);

(C) Ensure that its name and any identifier required by HHS prominently appears on the Internet Web site and on written materials containing QHP information that can be printed from the Web site, even if the agent or broker that is accessing the Internet Web site is able to customize the appearance of the Web site;

(D) Terminate the agent or broker's access to its Web site if HHS determines that the agent or broker is in violation of the provisions of this section and/or HHS terminates any required agreement with the agent or broker;

(E) Report to HHS and applicable State departments of insurance any potential material breach of the standards in paragraphs (c) and (d) of this section, or the agreement entered into under § 155.260(b), by the agent or broker accessing the internet website, should it become aware of any such potential breach. A web-broker that provides access to its website to complete the QHP selection or the Exchange eligibility application or ability to transact information with HHS to another web-broker website is responsible for ensuring compliance with applicable requirements in paragraph (c)(3) of this section for any web pages of the other web-broker's website that assist consumers, applicants, qualified individuals, and enrollees in applying for APTC and CSRs for QHPs, or in completing enrollment in QHPs, offered in the Exchanges.

(F) When an internet website of a web-broker is used to complete the Exchange eligibility application, obtain HHS approval verifying that all requirements in this section are met.

(ii) HHS retains the right to temporarily suspend the ability of a web-broker making its website available to transact information with HHS, if HHS discovers a security and privacy incident or breach, for the period in which HHS begins to conduct an investigation and until the incident or breach is remedied to HHS' satisfaction.

(5) HHS or its designee may periodically monitor and audit an agent, broker, or web-broker under this subpart to assess its compliance with the applicable requirements of this section.

(6) In addition to applicable requirements under § 155.221(b)(4), a web-broker must demonstrate operational readiness and compliance with applicable requirements prior to the web-broker's internet website being used to complete an Exchange eligibility application or a QHP selection, which may include submission or completion, in the form and manner specified by HHS, of the following:

(i) Operational data including licensure information, points of contact, and third-party relationships;

(ii) Enrollment testing, prior to approval or renewal;

(iii) Website reviews performed by HHS;

(iv) Security and privacy assessment documentation, including:

(A) Penetration testing results;

(B) Security and privacy assessment reports;

(C) Vulnerability scan results;

(D) Plans of action and milestones; and

(E) System security and privacy plans.

(v) Agreements between the web-broker and HHS.

(d) *Agreement.* An agent, broker, or web-broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with the terms of an agreement between the agent, broker, or web-broker and the Exchange under which the agent, broker, or web-broker at least:

(1) Registers with the Exchange in advance of assisting qualified individuals enrolling in QHPs through the Exchange;

(2) Receives training in the range of QHP options and insurance affordability programs, except that a licensed agent or broker entity that registers with the Federally-facilitated Exchange in its capacity as a business organized under the laws of a State, and not as an individual person, and direct enrollment technology providers are exempt from this requirement; and

(3) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260.

(e) *Compliance with State law.* An agent, broker, or web-broker that enrolls qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs must comply with applicable State law related to agents, brokers, or web-brokers including applicable State law related to confidentiality and conflicts of interest.

(f) *Termination notice to HHS.* (1) An agent, broker, or web-broker may terminate its agreement with HHS by sending to HHS a written notice at least 30 days in advance of the date of intended termination.

(2) The notice must include the intended date of termination, but if it does not specify a date of termination, or the date provided is not acceptable to HHS, HHS may set a different termination date that will be no less than 30 days from the date on the agent's, broker's, or web-broker's notice of termination.

(3) Prior to the date of termination, an agent, broker, or web-broker should—

(i) Notify applicants, qualified individuals, or enrollees that the agent, broker, or web-broker is assisting, of the agent's, broker's, or web-broker's intended date of termination;

(ii) Continue to assist such individuals with Exchange-related eligibility and enrollment services up until the date of termination; and

(iii) Provide such individuals with information about alternatives available for obtaining additional assistance, including but not limited to the Federally-facilitated Exchange Web site.

(4) When the agreement between the agent, broker, or web-broker and the Exchange under paragraph (d) of this section is terminated under paragraph (f) of this section, the agent, broker, or web-broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of

the premium tax credit and cost-sharing reductions for QHPs. The agent's, broker's, or web-broker's agreement with the Exchange under § 155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges. the agent, broker, or web-broker and the Exchange under paragraph (d) of this section is terminated under paragraph (f) of this section, the agent, broker, or web-broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's, broker's, or web-broker's agreement with the Exchange under § 155.260(b) will also be terminated through the termination without cause process set forth in that agreement. The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(g) *Standards for termination for cause from the Federally-facilitated Exchange.* (1) If, in HHS' determination, a specific finding of noncompliance or pattern of noncompliance is sufficiently severe, HHS may terminate an agent's, broker's, or web-broker's agreement with the Federally-facilitated Exchange for cause.

(2) An agent, broker, or web-broker may be determined noncompliant if HHS finds that the agent, broker, or web-broker violated—

(i) Any standard specified under this section;

(ii) Any term or condition of the agreement with the Federally-facilitated Exchanges required under paragraph (d) of this section, or any term or condition of the agreement with the Federally-facilitated Exchange required under § 155.260(b);

(iii) Any State law applicable to agents, brokers, or web-brokers, as required under paragraph (e) of this section, including but not limited to State laws related to confidentiality and conflicts of interest; or

(iv) Any Federal law applicable to agents, brokers, or web-brokers.

(3)(i) Except as provided in paragraph (g)(3)(ii) of this section, HHS will notify the agent, broker, or web-broker of the specific finding of noncompliance or pattern of noncompliance made under paragraph (g)(1) of this section, and after 30 days from the date of the notice, may terminate the agreement for cause if the matter is not resolved to the satisfaction of HHS.

(ii) HHS may immediately terminate the agreement for cause upon notice to the agent or broker without any further opportunity to resolve the matter if an agent or broker fails to maintain the appropriate license under State law as an agent, broker, or insurance producer in every State in which the agent or broker actively assists consumers with applying for advance payments of the premium tax credit or cost-sharing reductions or with enrolling in QHPs through the Federally-facilitated Exchanges.

(4) After the applicable period in paragraph (g)(3) of this section has elapsed and the agreement under paragraph (d) of this section is terminated, the agent, broker, or web-broker will no longer be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of a qualified individual, qualified employer, or qualified employee in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent's, broker's, or web-broker's agreement with the Exchange under § 155.260(b)(2) will also be terminated through the process set forth in that agreement. The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(5) Fraud or abusive conduct—

(i)(A) If HHS reasonably suspects that an agent, broker, or web-broker may have may have engaged in fraud, or in abusive conduct that may cause imminent or ongoing consumer harm using personally identifiable information of an Exchange enrollee or applicant or in connection with an Exchange enrollment or application, HHS may temporarily suspend the agent's, broker's, or web-broker's agreements required under paragraph (d) of this section and under § 155.260(b) for up to 90 calendar days. Suspension will be effective on the date of the notice that HHS sends to the agent, broker, or web-broker advising of the suspension of the agreements.

(B) The agent, broker, or web-broker may submit evidence in a form and manner to be specified by HHS, to rebut the allegation during this 90-day period. If the agent, broker, or web-broker submits such evidence during the suspension period, HHS will review the evidence and make a determination whether to lift the suspension within 45 calendar days of receipt of such evidence. If the rebuttal evidence does not persuade HHS to lift the suspension, or if the agent, broker, or web-broker fails to submit rebuttal evidence during the suspension period, HHS may terminate the agent's, broker's, or web-broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause under paragraph (g)(5)(ii) of this section.

(ii) If there is a finding or determination by a Federal or State entity that an agent, broker, or web-broker engaged in fraud, or abusive conduct that may result in imminent or ongoing consumer harm, using personally identifiable information of Exchange enrollees or applicants or in connection with an Exchange enrollment or application, HHS will terminate the agent's, broker's, or web-broker's agreements required under paragraph (d) of this section and under § 155.260(b) for cause. The termination will be effective starting on the date of the notice that HHS sends to the agent, broker, or web-broker advising of the termination of the agreements.

(iii) During the suspension period under paragraph (g)(5)(i) of this section and following termination of the agreements under paragraph (g)(5)(i)(B) or (g)(5)(ii) of this section, the agent, broker, or web-broker will not be registered with the Federally-facilitated Exchanges, or be permitted to assist with or facilitate enrollment of qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or be permitted to assist individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs. The agent, broker, or web-broker must continue to protect any personally identifiable information accessed during the term of either of these agreements with the Federally-facilitated Exchanges.

(6) The State department of insurance or equivalent State agent or broker licensing authority will be notified by HHS in cases of suspensions or terminations effectuated under this paragraph (g).

(h) *Request for reconsideration of termination for cause from the Federally-facilitated Exchange.* (1) *Request for reconsideration.* An agent, broker, or web-broker whose agreement with the Federally-facilitated Exchange has been terminated may request reconsideration of such action in the manner and form established by HHS.

(2) *Timeframe for request.* The agent, broker, or web-broker must submit a request for reconsideration to the HHS reconsideration entity within 30 calendar days of the date of the written notice from HHS.

(3) *Notice of reconsideration decision.* The HHS reconsideration entity will provide the agent, broker, or web-broker with a written notice of the reconsideration decision within 60 calendar days of the date it receives the request for reconsideration. This decision will constitute HHS' final determination.

(i) *Use of agents' and brokers' and web-brokers' internet websites for SHOP.* For plan years beginning

on or after January 1, 2015, in States that permit this activity under State law, a SHOP may permit agents, brokers, and web-brokers to use an internet website to assist qualified employers and facilitate enrollment of enrollees in a QHP through the Exchange, under paragraph (c)(3) of this section.

(j) *Federally-facilitated Exchange standards of conduct.* (1) An agent, broker, or web-broker that assists with or facilitates enrollment of qualified individuals, qualified employers, or qualified employees, in coverage in a manner that constitutes enrollment through a Federally-facilitated Exchange, or assists individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs sold through a Federally-facilitated Exchange, must—

(i) Have executed the required agreement under paragraph § 155.260(b);

(ii) Be registered with the Federally-facilitated Exchanges under paragraph (d)(1) of this section; and (iii) Comply with the standards of conduct in paragraph (j)(2) of this section.

(2) Standards of conduct. An individual or entity described in paragraph (j)(1) of this section must—

(i) 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;

(ii) Provide the Federally-facilitated Exchanges with correct information, and document that eligibility application information has been reviewed by and confirmed to be accurate by the consumer, or the consumer's authorized representative designated in compliance with § 155.227, prior to the submission of information, under section 1411(b) of the Affordable Care Act, including but not limited to:

(A) Documenting that eligibility application information has been reviewed by and confirmed to be accurate by the consumer or the consumer's authorized representative must require the consumer or their authorized representative to take an action that produces a record that can be maintained by the individual or entity described in paragraph (j)(1) of this section and produced to confirm the consumer or their authorized representative has reviewed and confirmed the accuracy of the eligibility application information. Non-exhaustive examples of acceptable documentation include obtaining the signature of the consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, a written response (electronic or otherwise) from the consumer or their authorized representative to a communication sent by the agent, broker, or web-broker, or other similar means or methods specified by HHS in guidance.

(*1*) The documentation required under paragraph (j)(2)(ii)(A) of this section must include the date the information was reviewed, the name of the consumer or their authorized representative, an explanation of the attestations at the end of the eligibility application, and the name of the assisting agent, broker, or web-broker.

(*2*) An individual or entity described in paragraph (j)(1) of this section must maintain the documentation described in paragraph (j)(2)(ii)(A) of this section for a minimum of ten years, and produce the documentation upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

(B) Entering only an email address on an application for Exchange coverage or an application for advance payments of the premium tax credit and cost-sharing reductions for QHPs that belongs to the consumer or the consumer's authorized representative designated in compliance with § 155.227. A consumer's email address may only be entered with the consent of the consumer or the consumer's authorized representative. Properly entered email addresses must adhere to the following guidelines:

(*1*) The email address must be accessible by the consumer, or the consumer's authorized representative designated in compliance with § 155.227, and may not be accessible by the agent, broker, or web-broker assisting the consumer; and

(*2*) The email address may not have domains that belong to the agent, broker, or web-broker or their business or agency.

(C) Entering only a telephone number on an application for Exchange coverage or an application for advance payments of the premium tax credit and cost-sharing reductions for QHPs that belongs to the consumer or their authorized representative designated in compliance with § 155.227. Telephone numbers may not be the personal number or business number of the agent, broker, or web-broker assisting the consumer, or their business or agency, unless the telephone number is actually that of the consumer or their authorized representative.

(D) Entering only a mailing address on an application for Exchange coverage or an application for advance payments of the premium tax credit and cost-sharing reductions for QHPs that belongs to, or is primarily accessible by, the consumer or their authorized representative designated in compliance with § 155.227, is not for the exclusive or convenient use of the agent, broker, or web-broker, and is an actual residence or a secure location where the consumer or their authorized representative may receive correspondence, such as a P.O. Box or homeless shelter. Mailing addresses may not be that of the agent, broker, or web-broker assisting the consumer, or their business or agency, unless the address is the actual residence of the consumer or their authorized representative.

(E) When submitting household income projections used by the Exchange to determine a tax filer's eligibility for advance payments of the premium tax credit in accordance with § 155.305(f) or cost-sharing reductions in accordance with § 155.305(g), entering only a consumer's household income projection that the consumer or the consumer's authorized representative designated in compliance with § 155.227 has knowingly authorized and confirmed as accurate. Household income projections must be calculated and attested to by the consumer. The agent, broker, or web-broker assisting the consumer may answer questions posed by the consumer related to household income projection, such as helping the consumer determine what qualifies as income.

(iii) Obtain and document the receipt of consent of the consumer or their authorized representative designated in compliance with § 155.227, employer, or employee prior to assisting with or facilitating enrollment through a Federally-facilitated Exchange or assisting the individual in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs;

(A) Obtaining and documenting the receipt of consent must require the consumer, or the consumer's authorized representative designated in compliance with § 155.227, to take an action that produces a record that can be maintained and produced by an individual or entity described in paragraph (j)(1) of this section to confirm the consumer's or their authorized representative's consent has been provided. Non-exhaustive examples of acceptable documentation of consent include obtaining the signature of the

consumer or their authorized representative (electronically or otherwise), verbal confirmation by the consumer or their authorized representative that is captured in an audio recording, a response from the consumer or their authorized representative to an electronic or other communication sent by the agent, broker, or web-broker, or other similar means or methods specified by HHS in guidance.

(B) The documentation required under paragraph (j)(2)(iii)(A) of this section must include a description of the scope, purpose, and duration of the consent provided by the consumer or their authorized representative designated in compliance with § 155.227, the date consent was given, name of the consumer or their authorized representative, and the name of the agent, broker, web-broker, or agency being granted consent, as well as a process through which the consumer or their authorized representative may rescind the consent.

(C) An individual or entity described in paragraph (j)(1) of this section must maintain the documentation described in paragraph (j)(2)(iii)(A) of this section for a minimum of 10 years, and produce the documentation upon request in response to monitoring, audit, and enforcement activities conducted consistent with paragraphs (c)(5), (g), (h), and (k) of this section.

(iv) Protect consumer personally identifiable information according to § 155.260(b)(3) and the agreement described in § 155.260(b)(2);

(v) Comply with all applicable Federal and State laws and regulations.

(vi) Not engage in scripting and other automation of interactions with CMS Systems or the Direct Enrollment Pathways, unless approved in advance in writing by CMS.

(vii) Only use an identity that belongs to the consumer when identity proofing the consumer's account on *HealthCare.gov*.

(viii) When providing information to Federally-facilitated Exchanges that may result in a determination of eligibility for a special enrollment period in accordance with § 155.420, obtain authorization from the consumer to submit the request for a determination of eligibility for a special enrollment period and make the consumer aware of the specific triggering event and special enrollment period for which the agent, broker, or web-broker will be submitting an eligibility determination request on the consumer's behalf.

(3) If an agent, broker, or web-broker fails to provide correct information, he, she, or it will nonetheless be deemed in compliance with paragraphs (j)(2)(i) and (ii) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information and that the agent, broker, or web-broker acted in good faith.

(k) *Penalties other than termination of the agreement with the Federally-facilitated Exchanges.* (1) If HHS determines that an agent, broker, or web-broker has failed to comply with the requirements of this section, in addition to any other available remedies, that agent, broker, or web-broker—

(i) May be denied the right to enter into agreements with the Federally-facilitated Exchanges in future years; and

(ii) May be subject to civil money penalties as described in § 155.285.

(2) HHS will notify the agent, broker, or web-broker of the proposed imposition of penalties under paragraph (k)(1)(i) of this section as part of the termination notice issued under paragraph (g) of this section and, after 30 calendar days from the date of the notice, may impose the penalty if the agent, broker, or web-broker has not requested a reconsideration under paragraph (h) of this section. The proposed imposition of penalties under paragraph (k)(1)(ii) of this section will follow the process outlined under § 155.285.

(3) HHS may immediately suspend the agent's or broker's ability to transact information with the Exchange if HHS discovers circumstances that pose unacceptable risk to Exchange operations or

Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS' satisfaction.

(l) *Application to State Exchanges using a Federal platform.* An agent, broker, or web-broker who enrolls qualified individuals, qualified employers, or qualified employees in coverage in a manner that constitutes enrollment through a State Exchange using the Federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through a State Exchange using the Federal platform must comply with all applicable Federally-facilitated Exchange standards in this section.

(m) *Web-broker agreement suspension, termination, and denial and information collection.* (1) A web-broker's agreement executed under paragraph (d) of this section, may be suspended or terminated under paragraph (g) of this section, and a web-broker may be denied the right to enter into agreements with the Federally-facilitated Exchanges under paragraph (k)(1)(i) of this section, based on the actions of its officers, employees, contractors, or agents, whether or not the officer, employee, contractor, or agent is registered with the Exchange as an agent or broker.

(2) A web-broker's agreement executed under paragraph (d) of this section may be suspended or terminated under paragraph (g) of this section, and a web-broker may be denied the right to enter into agreements with the Federally-facilitated Exchanges under paragraph (k)(1)(i) of this section, if it is under the common ownership or control or is an affiliated business of another web-broker that had its agreement suspended or terminated under paragraph (g) of this section.

(3) The Exchange may collect information from a web-broker during its registration with the Exchange under paragraph (d)(1) of this section, or at another time on an annual basis, in a form and manner to be specified by HHS, sufficient to establish the identities of the individuals who comprise its corporate ownership and leadership and to ascertain any corporate or business relationships it has with other entities that may seek to register with the Federally-facilitated Exchange as web-brokers.

§ 155.221 Standards for direct enrollment entities and for third-parties to perform audits of direct enrollment entities.

(a) *Direct enrollment entities.* The Federally-facilitated Exchanges will permit the following entities to assist consumers with direct enrollment in QHPs offered through the Exchange in a manner that is considered to be through the Exchange, to the extent permitted by applicable State law:

(1) QHP issuers that meet the applicable requirements in this section and § 156.1230 of this subchapter; and

(2) Web-brokers that meet the applicable requirements in this section and § 155.220.

(b) *Direct enrollment entity requirements.* For the Federally-facilitated Exchanges, a direct enrollment entity must:

(1) Display and market QHPs offered through the Exchange, individual health insurance coverage as defined in § 144.103 of this subchapter offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits), and any other products, such as excepted benefits, on at least three separate website pages on its non-Exchange website, except as permitted under paragraph (c) of this section;

(2) Prominently display a standardized disclaimer in the form and manner provided by HHS;

(3) Limit marketing of non-QHPs during the Exchange eligibility application and QHP selection process in a manner that minimizes the likelihood that consumers will be confused as to which products and plans are available through the Exchange and which products and plans are not, except as permitted under paragraph (c)(1) of this section;

(4) Demonstrate operational readiness and compliance with applicable requirements prior to the direct enrollment entity's internet website being used to complete an Exchange eligibility application or a QHP selection, which may include submission or completion, in the form and manner specified by HHS, of the following:

(i) Business audit documentation including:

(A) Notices of intent to participate including auditor information;

(B) Documentation packages including privacy questionnaires, privacy policy statements, and terms of service; and

(C) Business audit reports including testing results.

(ii) Security and privacy audit documentation including:

(A) Interconnection security agreements;

(B) Security and privacy controls assessment test plans;

(C) Security and privacy assessment reports;

(D) Plans of action and milestones;

(E) Privacy impact assessments;

(F) System security and privacy plans;

(G) Incident response plans; and

(H) Vulnerability scan results.

(iii) Eligibility application audits performed by HHS;

(iv) Online training modules offered by HHS; and

(v) Agreements between the direct enrollment entity and HHS.

(5) Comply with applicable Federal and State requirements.

(c) *Exceptions to direct enrollment entity display and marketing requirement.* For the Federally-facilitated Exchanges, a direct enrollment entity may:

(1) Display and market QHPs offered through the Exchange and individual health insurance coverage as defined in § 144.103 of this subchapter offered outside the Exchange (including QHPs and non-QHPs other than excepted benefits) on the same website pages when assisting individuals who have communicated receipt of an offer of an individual coverage health reimbursement arrangement as described in § 146.123(c) of this subchapter, as a standalone benefit, or in addition to an offer of an arrangement under which the individual may pay the portion of the premium for individual health insurance coverage that is not covered by an individual coverage health reimbursement arrangement using a salary reduction arrangement pursuant to a cafeteria plan under section 125 of the Internal Revenue Code, but must clearly distinguish between the QHPs offered through the Exchange and individual health insurance coverage offered outside the Exchange (including QHPs and non- QHPs other than excepted benefits), and prominently communicate that advance payments of the premium tax credit and cost-sharing reductions are available only for QHPs purchased through the Exchange, that advance payments of the premium tax credit are not available to individuals who accept an offer of an individual coverage health reimbursement arrangement or who opt out of an individual coverage health reimbursement arrangement that is considered affordable, and that a salary reduction arrangement under a cafeteria plan may only be used toward the cost of premiums for plans purchased outside the Exchange; and

(2) Display and market Exchange-certified stand-alone dental plans offered outside the Exchange and noncertified stand-alone dental plans on the same website pages.

(d) *Direct enrollment entity application assister requirements.* For the Federally-facilitated Exchanges, to the extent permitted under state law, a direct enrollment entity may permit its direct enrollment entity application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, provided that such direct enrollment entity ensures that each of its direct enrollment entity application assisters meets the requirements in § 155.415(b).

(e) *Federally-facilitated Exchange direct enrollment entity suspension.* HHS may immediately suspend the direct enrollment entity's ability to transact

information with the Exchange if HHS discovers circumstances that pose unacceptable risk to the accuracy of the Exchange's eligibility determinations, Exchange operations, or Exchange information technology systems until the incident or breach is remedied or sufficiently mitigated to HHS' satisfaction.

(f) *Third parties to perform audits of direct enrollment entities.* A direct enrollment entity must engage an independent, third-party entity to conduct an initial and annual review to demonstrate the direct enrollment entity's operational readiness and compliance with applicable direct enrollment entity requirements in accordance with paragraph (b)(4) of this section prior to the direct enrollment entity's internet website being used to complete an Exchange eligibility application or a QHP selection. The third-party entity will be a downstream or delegated entity of the direct enrollment entity that participates or wishes to participate in direct enrollment.

(g) *Third-party auditor standards.* A direct enrollment entity must satisfy the requirement to demonstrate operational readiness under paragraph (f) of this section by engaging a third-party entity that executes a written agreement with the direct enrollment entity under which the third-party entity agrees to comply with each of the following standards:

(1) Has experience conducting audits or similar services, including experience with relevant privacy and security standards;

(2) Adheres to HHS specifications for content, format, privacy, and security in the conduct of an operational readiness review, which includes ensuring that direct enrollment entities are in compliance with the applicable privacy and security standards and other applicable requirements;

(3) Collects, stores, and shares with HHS all data related to the third-party entity's audit of direct enrollment entities in a manner, format, and frequency specified by HHS until 10 years from the date of creation, and complies with the privacy and security standards HHS adopts for direct enrollment entities as required in accordance with § 155.260;

(4) Discloses to HHS any financial relationships between the entity and individuals who own or are employed by a direct enrollment entity for which it is conducting an operational readiness review;

(5) Complies with all applicable Federal and State requirements;

(6) Ensures, on an annual basis, that appropriate staff successfully complete operational readiness review training as established by HHS prior to conducting audits under paragraph (f) of this section;

(7) Permits access by the Secretary and the Office of the Inspector General or their designees in connection with their right to evaluate through audit, inspection, or other means, to the third-party entity's books, contracts, computers, or other electronic systems, relating to the third-party entity's audits of a direct enrollment entity's obligations in accordance with standards under paragraph (f) of this section until 10 years from the date of creation of a specific audit; and

(8) Complies with other minimum business criteria as specified in guidance by HHS.

(h) *Multiple auditors.* A direct enrollment entity may engage multiple third-party entities to conduct the audit under paragraph (f) of this section.

(i) *Application to State Exchanges using a Federal platform.* A direct enrollment entity that enrolls qualified individuals in coverage in a manner that constitutes enrollment through a State Exchange using the Federal platform, or assists individual market consumers with submission of applications for advance payments of the premium tax credit and cost-sharing reductions through a State Exchange using a Federal platform must comply with all applicable Federally-facilitated Exchange standards in this section.

§ 155.222 Standards for HHS-approved vendors of Federally-facilitated Exchange training for agents and brokers.

(a) *Application for approval.* (1) A vendor must be approved by HHS, in a form and manner to be determined by HHS, to have its training program recognized for agents and brokers assisting with or

facilitating enrollment in individual market or SHOP coverage through the Federally-facilitated Exchanges consistent with § 155.220.

(2) As part of the training program, the vendor must require agents and brokers to provide identifying information and successfully complete the required curriculum.

(3) HHS will approve vendors on an annual basis for a given plan year, and each vendor must submit an application for each year that approval is sought.

(b) *Standards.* To be approved by HHS and maintain its status as an approved vendor for plan year 2016 and future plan years, a vendor must meet each of the following standards:

(1) Submit a complete and accurate application by the deadline established by HHS, which includes demonstration of prior experience with successfully conducting online training, as well as providing technical support to a large customer base.

(2) Adhere to HHS specifications for content, format, and delivery of training, which includes offering continuing education units (CEUs) for at least five States in which a Federally-facilitated Exchange or State-Based Exchange using a Federal platform is operating.

(3) Collect, store, and share with HHS training completion data from agent and broker users of the vendor's training in a manner, format, and frequency specified by HHS, and protect all data from agent and broker users of the vendor's training in accordance with applicable privacy and security requirements.

(4) Execute an agreement with HHS, in a form and manner to be determined by HHS, which requires the vendor to comply with applicable HHS guidelines for implementing the training and interfacing with HHS data systems, and the use of all data collected.

(5) Permit any individual who holds a valid State license or equivalent State authority to sell health insurance products to access the vendor's training.

(6) Provide technical support to agent and broker users of the vendor's training as specified by HHS.

(c) *Approved list.* A list of approved vendors will be published on an HHS Web site.

(d) *Monitoring.* HHS may periodically monitor and audit vendors approved under this subpart, and their records related to the training functions described in this section, to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved vendor is not in compliance with the standards required in paragraph (b) of this section, the vendor may be removed from the approved list described in paragraph (c) of this section and may be required by HHS to cease performing the training functions described under this subpart.

(e) *Appeals.* A vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section, or an approved vendor whose agreement is revoked under paragraph (d) of this section, may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section and (if applicable) the terms of its agreement with HHS. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.

§ 155.225 Certified application counselors.

(a) *General rule.* The Exchange must have a certified application counselor program that complies with the requirements of this section.

(b) *Exchange designation of organizations.* (1) The Exchange may designate an organization, including an organization designated as a Medicaid certified application counselor organization by a state Medicaid or CHIP agency, to certify its staff members or volunteers to act as certified application counselors who perform the duties and meet the standards and requirements for certified application counselors in this section if the organization—

(i) Enters into an agreement with the Exchange to comply with the standards and

requirements of this section including the standards specified in paragraphs (d)(3) through (d)(5) of this section; and

(ii) Maintains a registration process and method to track the performance of certified application counselors.

(iii) Provides data and information to the Exchange regarding the number and performance of its certified application counselors and regarding the consumer assistance provided by its certified application counselors, upon request, in the form and manner specified by the Exchange. Beginning for the third quarter of calendar year 2017, in a Federally-facilitated Exchange, organizations designated by the Exchange must submit quarterly reports that include, at a minimum, data regarding the number of individuals who have been certified by the organization; the total number of consumers who received application and enrollment assistance from the organization; and of that number, the number of consumers who received assistance in applying for and selecting a QHP, enrolling in a QHP, or applying for Medicaid or CHIP.

(2) An Exchange may comply with paragraph (a) of this section either by—

(i) Designating organizations to certify application counselors in compliance with paragraph (b)(1) of this section;

(ii) Directly certifying individual staff members or volunteers of Exchange designated organizations to provide the duties specified in paragraph (c) of this section if the staff member or volunteer enters into an agreement with the Exchange to comply with the standards and requirements for certified application counselors in this section; or

(iii) A combination of paragraphs (b)(2)(i) and (b)(2)(ii) of this section.

(3) In a Federally-facilitated Exchange, no individual or entity shall be ineligible to operate as a certified application counselor or organization designated by the Exchange under paragraph (b) of this section solely because its principal place of business is outside of the Exchange service area.

(c) *Duties.* Certified application counselors are certified to—

(1) Provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible, which includes: providing fair, impartial, and accurate information that assists consumers with submitting the eligibility application; clarifying the distinctions among health coverage options, including QHPs; and helping consumers make informed decisions during the health coverage selection process;

(2) Assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs; and

(3) Help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs.

(d) *Standards of certification.* An organization designated by the Exchange to provide certified application counselor services, or an Exchange that chooses to certify individual staff members or volunteers directly under paragraph (b)(2)(ii) of this section, may certify a staff member or volunteer to perform the duties specified in paragraph (c) of this section only if the staff member or volunteer—

(1) Completes Exchange approved training regarding QHP options, insurance affordability programs, eligibility, and benefits rules and regulations governing all insurance affordability programs operated in the state, as implemented in the state, and completes and achieves a passing score on all Exchange approved certification examinations, prior to functioning as a certified application counselor;

(2) Discloses to the organization, or to the Exchange if directly certified by an Exchange, and potential applicants any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest;

(3) Complies with the Exchange's privacy and security standards adopted consistent with

§ 155.260, and applicable authentication and data security standards;

(4) Agrees to act in the best interest of the applicants assisted;

(5) Either directly or through an appropriate referral to a Navigator or non-Navigator assistance personnel authorized under §§ 155.205(d) and (e) or 155.210, or to the Exchange call center authorized under § 155.205(a), provides information in a manner that is accessible to individuals with disabilities, as defined by the Americans with Disabilities Act, as amended, 42 U.S.C. 12101 et seq. and section 504 of the Rehabilitation Act, as amended, 29 U.S.C. 794;

(6) Enters into an agreement with the organization regarding compliance with the standards specified in paragraphs (d), (f), and (g) of this section;

(7) Is recertified on at least an annual basis after successfully completing recertification training as required by the Exchange; and

(8) Meets any licensing, certification, or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not limited to the following:

(i) Requirements that certified application counselors refer consumers to other entities not required to provide fair, accurate, and impartial information.

(ii) Requirements that would prevent certified application counselors from providing services to all persons to whom they are required to provide assistance.

(iii) Requirements that would prevent certified application counselors from providing advice regarding substantive benefits or comparative benefits of different health plans.

(iv) Imposing standards that would, as applied or as implemented in a State, prevent the application of Federal requirements applicable to certified application counselors, to an organization designated by the Exchange under paragraph (b) of this section, or to the Exchange's implementation of the certified application counselor program.

(e) *Withdrawal of designation and certification.* (1) The Exchange must establish procedures to withdraw designation from a particular organization it has designated under paragraph (b) of this section, when it finds noncompliance with the terms and conditions of the organization's agreement required by paragraph (b) of this section.

(2) If an Exchange directly certifies organizations' individual certified application counselors, it must establish procedures to withdraw certification from individual certified application counselors when it finds noncompliance with the requirements of this section.

(3) An organization designated by the Exchange under paragraph (b) of this section must establish procedures to withdraw certification from individual certified application counselors when it finds noncompliance with the requirements of this section.

(f) *Availability of information; authorization.* An organization designated by the Exchange under paragraph (b) of this section, or, if applicable, an Exchange that certifies staff members or volunteers of organizations directly must establish procedures to ensure that applicants—

(1) Are informed, prior to receiving assistance, of the functions and responsibilities of certified application counselors, including that certified application counselors are not acting as tax advisers or attorneys when providing assistance as certified application counselors and cannot provide tax or legal advice within their capacity as certified application counselors;

(2) Provide authorization in a form and manner as determined by the Exchange prior to a certified application counselor obtaining access to an applicant's personally identifiable information, and that the organization or certified application counselor maintains a record of the authorization in a form and manner as determined by the Exchange. The Exchange must establish a

reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is no less than six years, unless a different and longer retention period has already been provided under other applicable Federal law; and

(3) May revoke at any time the authorization provided the certified application counselor, pursuant to paragraph (f)(2) of this section.

(g) *Fees, consideration, solicitation, and marketing.* Organizations designated by the Exchange under paragraph (b) of this section and certified application counselors must not—

(1) Impose any charge on applicants or enrollees for application or other assistance related to the Exchange;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individuals in a QHP or a non-QHP. In a Federally-facilitated Exchange, no health care provider shall be ineligible to operate as a certified application counselor or organization designated by the Exchange under paragraph (b) of this section solely because it receives consideration from a health insurance issuer for health care services provided;

(3) Beginning November 15, 2014, if operating in a Federally-facilitated Exchange, provide compensation to individual certified application counselors on a per-application, per-individual-assisted, or per-enrollment basis;

(4) Provide to an applicant or potential enrollee gifts of any value as an inducement for enrollment. The value of gifts provided to applicants and potential enrollees for purposes other than as an inducement for enrollment must not exceed nominal value, either individually or in the aggregate, when provided to that individual during a single encounter. For purposes of this paragraph (g)(4), the term gifts includes gift items, gift cards, cash cards, cash, and promotional items that market or promote the products or services of a third party, but does not include the reimbursement of legitimate expenses incurred by a consumer in an effort to receive Exchange application assistance, such as travel or postage expenses; or

(5) [Reserved]

(6) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice, except in cases where the individual certified application counselor or designated organization has a relationship with the consumer and so long as other applicable State and Federal laws are otherwise complied with.

§ 155.227 Authorized representatives.

(a) *General rule.* (1) The Exchange must permit an applicant or enrollee in the individual or small group market, subject to applicable privacy and security requirements, to designate an individual person or organization to act on his or her behalf in applying for an eligibility determination or redetermination, under subpart D, G, or H of this part, and in carrying out other ongoing communications with the Exchange.

(2) Designation of an authorized representative must be in a written document signed by the applicant or enrollee, or through another legally binding format subject to applicable authentication and data security standards. If submitted, legal documentation of authority to act on behalf of an applicant or enrollee under State law, such as a court order establishing legal guardianship or a power of attorney, shall serve in the place of the applicant's or enrollee's signature.

(3) The Exchange must ensure that the authorized representative agrees to maintain, or be legally bound to maintain, the confidentiality of any information regarding the applicant or enrollee provided by the Exchange.

(4) The Exchange must ensure that the authorized representative is responsible for fulfilling all responsibilities encompassed within the scope of the authorized representation, as described in this section, to the same extent as the applicant or enrollee he or she represents.

(5) The Exchange must provide information both to the applicant or enrollee, and to the authorized representative, regarding the powers and duties of authorized representatives.

(b) *Timing of designation.* The Exchange must permit an applicant or enrollee to designate an authorized representative:

(1) At the time of application; and

(2) At other times and through methods as described in § 155.405(c)(2).

(c) *Duties.* (1) The Exchange must permit an applicant or enrollee to authorize his or her representative to:

(i) Sign an application on the applicant or enrollee's behalf;

(ii) Submit an update or respond to a redetermination for the applicant or enrollee in accordance with § 155.330 or § 155.335;

(iii) Receive copies of the applicant's or enrollee's notices and other communications from the Exchange; and

(iv) Act on behalf of the applicant or enrollee in all other matters with the Exchange.

(2) The Exchange may permit an applicant or enrollee to authorize a representative to perform fewer than all of the activities described in paragraph (c)(1) of this section, provided that the Exchange tracks the specific permissions for each authorized representative.

(d) *Duration.* The Exchange must consider the designation of an authorized representative valid until:

(1) The applicant or enrollee notifies the Exchange that the representative is no longer authorized to act on his or her behalf using one of the methods available for the submission of an application, as described in § 155.405(c). The Exchange must notify the authorized representative of such change; or

(2) The authorized representative informs the Exchange and the applicant or enrollee that he or she no longer is acting in such capacity. An authorized representative must notify the Exchange and the applicant or enrollee on whose behalf he or she is acting when the authorized representative no longer has legal authority to act on behalf of the applicant or enrollee.

(e) *Compliance with State and Federal law.* The Exchange must require an authorized representative to comply with applicable state and federal laws concerning conflicts of interest and confidentiality of information.

(f) *Signature.* For purposes of this section, designation of an authorized representative must be through a written document signed by the applicant or enrollee, or through another legally binding format, as described in § 155.227(a)(2), and must be accepted through all of the modalities described in § 155.405(c).

§ 155.230 General standards for Exchange notices.

(a) *General requirement.* Any notice required to be sent by the Exchange to individuals or employers must be written and include:

(1) An explanation of the action reflected in the notice, including the effective date of the action.

(2) Any factual findings relevant to the action.

(3) Citations to, or identification of, the relevant regulations supporting the action.

(4) Contact information for available customer service resources.

(5) An explanation of appeal rights, if applicable.

(b) *Accessibility and readability requirements.* All applications, forms, and notices, including the single, streamlined application described in § 155.405 and notice of annual redetermination described in § 155.335(c), must conform to the standards outlined in § 155.205(c).

(c) *Re-evaluation of appropriateness and usability.* The Exchange must reevaluate the appropriateness and usability of applications, forms, and notices.

(d) *Electronic notices.* (1) The individual market Exchange must provide required notices either through standard mail, or if an individual or employer elects, electronically, provided that the requirements for electronic notices in 42 CFR 435.918 are met, except that the individual market Exchange is not

required to implement the process specified in 42 CFR 435.918(b)(1) for eligibility determinations for enrollment in a QHP through the Exchange and insurance affordability programs that are effective before January 1, 2015.

(2) Unless otherwise required by Federal or State law, the SHOP must provide required notices electronically or, if an employer or employee elects, through standard mail. If notices are provided electronically, the SHOP must comply with the requirements for electronic notices in 42 CFR 435.918(b)(2) through (5) for the employer or employee.

(3) In the event that an individual market Exchange or SHOP is unable to send select required notices electronically due to technical limitations, it may instead send these notices through standard mail, even if an election has been made to receive such notices electronically.

§ 155.240 Payment of premiums.

(a) *Payment by individuals.* The Exchange must allow a qualified individual to pay any applicable premium owed by such individual directly to the QHP issuer.

(b) *Payment by tribes, tribal organizations, and urban Indian organizations.* The Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay aggregated QHP premiums on behalf of qualified individuals, including aggregated payment, subject to terms and conditions determined by the Exchange.

(c) *Payment facilitation.* The Exchange may establish a process to facilitate through electronic means the collection and payment of premiums to QHP issuers.

(d) *Required standards.* In conducting an electronic transaction with a QHP issuer that involves the payment of premiums or an electronic funds transfer, the Exchange must comply with the privacy and security standards adopted in accordance with § 155.260 and use the standards and operating rules referenced in § 155.270.

(e) *Premium calculation.* The Exchange may establish one or more standard processes for premium calculation.

(1) For a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of—

(i) The premium for one month of coverage divided by the number of days in the month; and

(ii) The number of days for which coverage is being provided in the month described in paragraph (e)(1)(i) of this section.

(2) [Reserved]

§ 155.260 Privacy and security of personally identifiable information.

(a) *Creation, collection, use and disclosure.* (1) Where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in § 155.300; or determining eligibility for exemptions from the individual shared responsibility provisions in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information to the extent such information is necessary:

(i) For the Exchange to carry out the functions described in § 155.200;

(ii) For the Exchange to carry out other functions not described in paragraph (a)(1)(i) of this section, which the Secretary determines to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act and for which an individual provides consent for his or her information to be used or disclosed; or

(iii) For the Exchange to carry out other functions not described in paragraphs (a)(1)(i) and (ii) of this section, for which an individual provides consent for his or her information to be used or disclosed, and which the Secretary determines are in compliance with section 1411(g)(2)(A) of the Affordable Care Act under the following substantive and procedural requirements:

(A) *Substantive requirements.* The Secretary may approve other uses and disclosures of personally identifiable information created or collected as described in paragraph (a)(1) of this section that are not described in paragraphs (a)(1)(i) or (ii) of this section, provided that HHS determines that the information will be used only for the purposes of and to the extent necessary in ensuring the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act, and that the uses and disclosures are also permissible under relevant law and policy.

(B) *Procedural requirements for approval of a use or disclosure of personally identifiable information.* To seek approval for a use or disclosure of personally identifiable information created or collected as described in paragraph (a)(1) of this section that is not described in paragraphs (a)(1)(i) or (ii) of this section, the Exchange must submit the following information to HHS:

(*1*) Identity of the Exchange and appropriate contact persons;

(*2*) Detailed description of the proposed use or disclosure, which must include, but not necessarily be limited to, a listing or description of the specific information to be used or disclosed and an identification of the persons or entities that may access or receive the information;

(*3*) Description of how the use or disclosure will ensure the efficient operation of the Exchange consistent with section 1411(g)(2)(A) of the Affordable Care Act; and

(*4*) Description of how the information to be used or disclosed will be protected in compliance with privacy and security standards that meet the requirements of this section or other relevant law, as applicable.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information unless the creation, collection, use, or disclosure is consistent with this section.

(3) The Exchange must establish and implement privacy and security standards that are consistent with the following principles:

(i) *Individual access.* Individuals should be provided with a simple and timely means to access and obtain their personally identifiable information in a readable form and format;

(ii) *Correction.* Individuals should be provided with a timely means to dispute the accuracy or integrity of their personally identifiable information and to have erroneous information corrected or to have a dispute documented if their requests are denied;

(iii) *Openness and transparency.* There should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable information;

(iv) *Individual choice.* Individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information;

(v) *Collection, use, and disclosure limitations.* Personally identifiable information should be created, collected, used, and/or disclosed only to the extent necessary to accomplish a specified purpose(s) and never to discriminate inappropriately;

(vi) *Data quality and integrity.* Persons and entities should take reasonable steps to ensure that personally identifiable information is complete, accurate, and up-to-date to the extent necessary for the person's or entity's intended purposes and has not been altered or destroyed in an unauthorized manner;

(vii) *Safeguards.* Personally identifiable information should be protected with reasonable operational, administrative, technical, and physical safeguards to ensure its confidentiality, integrity, and availability

and to prevent unauthorized or inappropriate access, use, or disclosure; and,

(viii) *Accountability.* These principles should be implemented, and adherence assured, through appropriate monitoring and other means and methods should be in place to report and mitigate non-adherence and breaches.

(4) For the purposes of implementing the principle described in paragraph (a)(3)(vii) of this section, the Exchange must establish and implement operational, technical, administrative and physical safeguards that are consistent with any applicable laws (including this section) to ensure—

(i) The confidentiality, integrity, and availability of personally identifiable information created, collected, used, and/or disclosed by the Exchange;

(ii) Personally identifiable information is only used by or disclosed to those authorized to receive or view it;

(iii) Return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code;

(iv) Personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information;

(v) Personally identifiable information is protected against any reasonably anticipated uses or disclosures of such information that are not permitted or required by law; and

(vi) Personally identifiable information is securely destroyed or disposed of in an appropriate and reasonable manner and in accordance with retention schedules;

(5) The Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls.

(6) The Exchange must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

(b) *Application to non-Exchange entities.* (1) *Non-Exchange entities.* A non-Exchange entity is any individual or entity that:

(i) Gains access to personally identifiable information submitted to an Exchange; or

(ii) Collects, uses, or discloses personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing functions agreed to with the Exchange.

(2) Prior to any person or entity becoming a non-Exchange entity, Exchanges must execute with the person or entity a contract or agreement that includes:

(i) A description of the functions to be performed by the non-Exchange entity;

(ii) A provision(s) binding the non- Exchange entity to comply with the privacy and security standards and obligations adopted in accordance with paragraph (b)(3) of this section, and specifically listing or incorporating those privacy and security standards and obligations;

(iii) A provision requiring the non- Exchange entity to monitor, periodically assess, and update its security controls and related system risks to ensure the continued effectiveness of those controls in accordance with paragraph (a)(5) of this section;

(iv) A provision requiring the non- Exchange entity to inform the Exchange of any change in its administrative, technical, or operational environments defined as material within the contract; and

(v) A provision that requires the non-Exchange entity to bind any downstream entities to the same privacy and security standards and obligations to which the non-Exchange entity has agreed in its contract or agreement with the Exchange.

(3) When collection, use or disclosure is not otherwise required by law, the privacy and security standards to which an Exchange binds non-Exchange entities must:

(i) Be consistent with the principles and requirements listed in paragraphs (a)(1) through (6) of this section, including being at least as protective as the standards the Exchange has established and implemented for itself in compliance with paragraph (a)(3) of this section;

(ii) Comply with the requirements of paragraphs (c), (d), (f), and (g) of this section; and

(iii) Take into specific consideration:

(A) The environment in which the non-Exchange entity is operating;

(B) Whether the standards are relevant and applicable to the non-Exchange entity's duties and activities in connection with the Exchange; and

(C) Any existing legal requirements to which the non-Exchange entity is bound in relation to its administrative, technical, and operational controls and practices, including but not limited to, its existing data handling and information technology processes and protocols.

(c) *Workforce compliance.* The Exchange must ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

(d) *Written policies and procedures.* Policies and procedures regarding the creation, collection, use, and disclosure of personally identifiable information must, at minimum:

(1) Be in writing, and available to the Secretary of HHS upon request; and

(2) Identify applicable law governing collection, use, and disclosure of personally identifiable information.

(e) *Data sharing.* Data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP for the exchange of eligibility information must:

(1) Meet any applicable requirements described in this section;

(2) Meet any applicable requirements described in section 1413(c)(1) and (c)(2) of the Affordable Care Act;

(3) Be equal to or more stringent than the requirements for Medicaid programs under section 1942 of the Act; and

(4) For those matching agreements that meet the definition of "matching program" under 5 U.S.C. 552a(a)(8), comply with 5 U.S.C. 552a(o).

(f) *Compliance with the Code.* Return information, as defined in section 6103(b)(2) of the Code, must be kept confidential and disclosed, used, and maintained only in accordance with section 6103 of the Code.

(g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than $25,000 as adjusted annually under 45 C.F.R. part 102 per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at § 155.285, in addition to other penalties that may be prescribed by law.

§ 155.270 Use of standards and protocols for electronic transactions.

(a) *HIPAA administrative simplification.* To the extent that the Exchange performs electronic transactions with a covered entity, the Exchange must use standards, implementation specifications, operating rules, and code sets that are adopted by the Secretary in 45 CFR parts 160 and 162 or that are otherwise approved by HHS.

(b) *HIT enrollment standards and protocols.* The Exchange must incorporate interoperable and secure standards and protocols developed by the Secretary in accordance with section 3021 of the PHS Act. Such

standards and protocols must be incorporated within Exchange information technology systems.

§ 155.280 Oversight and monitoring of privacy and security requirements.

(a) *General.* HHS will oversee and monitor the Federally-facilitated Exchanges, State-based Exchanges on the Federal platform, and non-Exchange entities required to comply with the privacy and security standards established and implemented by a Federally-facilitated Exchange pursuant to § 155.260 for compliance with those standards. HHS will oversee and monitor State Exchanges for compliance with the standards State Exchanges establish and implement pursuant to § 155.260. State Exchanges will oversee and monitor non-Exchange entities required to comply with the privacy and security standards established and implemented by a State Exchange in accordance to § 155.260.

(b) *Audits and investigations.* HHS may conduct oversight activities that include but are not limited to the following: audits, investigations, inspections, and any reasonable activities necessary for appropriate oversight of compliance with the Exchange privacy and security standards. HHS may also pursue civil, criminal or administrative proceedings or actions as determined necessary.

§ 155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

(a) *Grounds for imposing civil money penalties.* (1) HHS may impose civil money penalties on any person, as defined in paragraph (a)(2) of this section, if, based on credible evidence, HHS reasonably determines that a person has engaged in one or more of the following actions:

(i) Failure to provide correct information under section 1411(b) of the Affordable Care Act where such failure is attributable to negligence or disregard of any rules or regulations of the Secretary with negligence and disregard defined as they are in section 6662 of the Internal Revenue Code of 1986:

(A) "Negligence" includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

(B) "Disregard" includes any careless, reckless, or intentional disregard for any rules or regulations of the Secretary.

(ii) Knowing and willful provision of false or fraudulent information required under section 1411(b) of the Affordable Care Act, where knowing and willful means the intentional provision of information that the person knows to be false or fraudulent; or

(iii) Knowing and willful use or disclosure of information in violation of section 1411(g) of the Affordable Care Act, where knowing and willful means the intentional use or disclosure of information in violation of section 1411(g). Such violations would include, but not be limited to, the following:

(A) Any use or disclosure performed which violates relevant privacy and security standards established by the Exchange pursuant to § 155.260;

(B) Any other use or disclosure which has not been determined by the Secretary to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act pursuant to § 155.260(a); and

(C) Any other use or disclosure which is not necessary to carry out a function described in a contract with a non-Exchange entity executed pursuant to § 155.260(b)(2).

(2) For purposes of this section, the term "person" is defined to include, but is not limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to personally identifiable information submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to § 155.260(a)(1); and non- Exchange entities as defined in § 155.260(b) which includes agents, brokers, Web-brokers, QHP issuers, Navigators, non-Navigator assistance personnel, certified application counselors, in-person assistors, and other third party contractors.

(b) *Factors in determining the amount of civil money penalties imposed.* In determining the amount of civil money penalties, HHS may take into account factors which include, but are not limited to, the following:

(1) The nature and circumstances of the conduct including, but not limited to:

(i) The number of violations;

(ii) The severity of the violations;

(iii) The person's history with the Exchange including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior;

(iv) The length of time of the violation;

(v) The number of individuals affected or potentially affected;

(vi) The extent to which the person received compensation or other consideration associated with the violation;

(vii) Any documentation provided in any complaint or other information, as well as any additional information provided by the individual to refute performing the violation; and

(viii) Whether other remedies or penalties have been imposed for the same conduct or occurrence.

(2) The nature of the harm resulting from, or reasonably expected to result from, the violation, including but not limited to:

(i) Whether the violation resulted in actual or potential financial harm;

(ii) Whether there was actual or potential harm to an individual's reputation;

(iii) Whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage;

[Reserved]

(v) The actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of the information; and

(vi) Whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reductions than he or she would be eligible for if the correct information had been provided.

(3) No penalty will be imposed under paragraph (a)(1)(i) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information required under section 1411(b) of the Affordable Care Act and that the person acted in good faith.

(c) *Maximum penalty.* The amount of a civil money penalty will be determined by HHS in accordance with paragraph (b) of this section.

(1) The following provisions provide maximum penalties for a single "plan year," where "plan year" has the same meaning as at § 155.20:

(i) Any person who fails to provide correct information as specified in paragraph (a)(1)(i) of this section may be subject to a maximum civil money penalty of $25,000 as adjusted annually under 45 C.F.R. part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, pursuant to which a person fails to provide correct information.

(ii) Any person who knowingly and willfully provides false information as specified in paragraph (a)(1)(ii) of this section may be subject to a maximum civil money penalty of $250,000 as adjusted annually under 45 C.F.R. part 102 for each application, as defined at paragraph (c)(1)(iii) of this section, on which a person knowingly and willfully provides false information.

(iii) For the purposes of this subsection, "application" is defined as a submission of information, whether through an online portal, over the telephone through a call center, or through a paper submission process, in which the information is provided in relation to an

eligibility determination; an eligibility redetermination based on a change in an individual's circumstances; or an annual eligibility redetermination for any of the following:

(A) Enrollment in a qualified health plan;

(B) Premium tax credits or cost sharing reductions; or

(C) An exemption from the individual shared responsibility payment.

(2) Any person who knowingly or willfully uses or discloses information as specified in paragraph (a)(1)(iii) of this section may be subject to the following civil money penalty:

(i) A civil money penalty for each use or disclosure described in paragraph (a)(1)(iii) of this section of not more than $25,000 as adjusted annually under 45 C.F.R. part 102 per use or disclosure.

(ii) For purposes of paragraph (c) of this section, a use or disclosure includes one separate use or disclosure of a single individual's personally identifiable information where the person against whom a civil money penalty may be imposed has made the use or disclosure.

(3) These penalties may be imposed in addition to any other penalties that may be prescribed by law.

(d) *Notice of intent to issue civil money penalty.* If HHS intends to impose a civil money penalty in accordance with this part, HHS will send a written notice of such intent to the person against whom it intends to impose a civil money penalty.

(1) This written notice will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. The written notice must include the following elements:

(i) A description of the findings of fact regarding the violations with respect to which the civil money penalty is proposed;

(ii) The basis and reasons why the findings of fact subject the person to a penalty;

(iii) Any circumstances described in paragraph (b) of this section that were considered in determining the amount of the proposed penalty;

(iv) The amount of the proposed penalty;

(v) An explanation of the person's right to a hearing under any applicable administrative hearing process;

(vi) A statement that failure to request a hearing within 60 calendar days after the date of issuance printed on the notice permits the assessment of the proposed penalty; and

(vii) Information explaining how to file a request for a hearing and the address to which the hearing request must be sent.

(2) The person may request a hearing before an ALJ on the proposed penalty by filing a request in accordance with the procedure to file an appeal specified in paragraph (f) of this section.

(e) *Failure to request a hearing.* If the person does not request a hearing within 60 calendar days of the date of issuance printed on the notice described in paragraph (d) of this section, HHS may impose the proposed civil money penalty.

(1) HHS will notify the person in writing of any penalty that has been imposed, the means by which the person may satisfy the penalty, and the date on which the penalty is due.

(2) A person has no right to appeal a penalty with respect to which the person has not timely requested a hearing in accordance with paragraph (d) of this section.

(f) *Appeal of proposed penalty.* Subject to paragraph (e)(2) of this section, any person against whom HHS proposed to impose a civil money penalty may appeal that penalty in accordance with the rules and procedures outlined at 45 CFR part 150, subpart D, excluding §§ 150.461, 150.463, and 150.465.

(g) *Enforcement authority.* (1) *HHS.* HHS may impose civil money penalties up to the maximum

amounts specified in paragraph (d) of this section for any of the violations described in paragraph (a) of this section.

(2) *OIG.* In accordance with the rules and procedures of 42 CFR part 1003, and in place of imposition of penalties by CMS, the OIG may impose civil money penalties for violations described in paragraph (a)(1)(ii) of this section.

(h) *Settlement authority.* Nothing in this section limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with § 155.285(d) or to compromise on any penalty provided for in this section.

(i) *Limitations.* No action under this section will be entertained unless commenced, in accordance with § 155.285(d), within 6 years from the date on which the violation occurred.

SUBPART D—EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET: ELIGIBILITY DETERMINATIONS FOR EXCHANGE PARTICIPATION AND INSURANCE AFFORDABILITY PROGRAMS

§ 155.300 Definitions and general standards for eligibility determinations.

(a) *Definitions.* In addition to those definitions in § 155.20, for purposes of this subpart, the following terms have the following meaning:

Applicable Children's Health Insurance Program (CHIP) MAGI-based income standard means the applicable income standard as defined at 42 CFR 457.310(b)(1), as applied under the State plan adopted in accordance with title XXI of the Act, or waiver of such plan and as certified by the State CHIP Agency in accordance with 42 CFR 457.348(d), for determining eligibility for child health assistance and enrollment in a separate child health program.

Applicable Medicaid modified adjusted gross income (MAGI)-based income standard has the same meaning as "applicable modified adjusted gross income standard," as defined at 42 CFR 435.911(b), as applied under the State plan adopted in accordance with title XIX of the Act, or waiver of such plan, and as certified by the State Medicaid agency in accordance with 42 CFR 435.1200(b)(2) for determining eligibility for Medicaid.

Federal poverty level or *FPL* means the most recently published Federal poverty level, updated periodically in the **Federal Register** by the Secretary of Health and Human Services under the authority of 42 U.S.C. 9902(2), as of the first day of the annual open enrollment period for coverage in a QHP through the Exchange, as specified in § 155.410.

Indian means any individual as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (Pub. L. 93–638).

Insurance affordability program has the same meaning as "insurance affordability program," as specified in 42 CFR 435.4.

MAGI-based income has the same meaning as it does in 42 CFR 435.603(e).

Minimum value when used to describe coverage in an eligible employer-sponsored plan, means that the employer-sponsored plan meets the standards for coverage of the total allowed costs of benefits set forth in § 156.145.

Modified Adjusted Gross Income (MAGI) has the same meaning as it does in 26 CFR 1.36B–1(e)(2).

Non-citizen means an individual who is not a citizen or national of the United States, in accordance with section 101(a)(3) of the Immigration and Nationality Act.

Qualifying coverage in an eligible employer-sponsored plan means coverage in an eligible employer-sponsored plan that meets the affordability and minimum value standards specified in 26 CFR 1.36B– 2(c)(3).

State CHIP Agency means the agency that administers a separate child health program established by the State under title XXI of the Act in accordance with implementing regulations at 42 CFR 457.

State Medicaid Agency means the agency established or designated by the State under title XIX of the Act

that administers the Medicaid program in accordance with implementing regulations at 42 CFR parts 430 through 456.

Tax dependent has the same meaning as the term dependent under section 152 of the Code.

Tax filer means an individual, or a married couple, who indicates that he, she or they expects—

(1) To file an income tax return for the benefit year, in accordance with 26 U.S.C. 6011, 6012, and implementing regulations;

(2) If married (within the meaning of 26 CFR 1.7703–1), to file a joint tax return for the benefit year;

(3) That no other taxpayer will be able to claim him, her or them as a tax dependent for the benefit year; and

(4) That he, she, or they expects to claim a personal exemption deduction under section 151 of the Code on his or her tax return for one or more applicants, who may or may not include himself or herself and his or her spouse.

(b) *Medicaid and CHIP.* In general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with rules and procedures which are the same as those applied by the State Medicaid or State CHIP agency or approved by such agency in the agreement described in § 155.345(a).

(c) *Attestation.* (1) Except as specified in paragraph (c)(2) of this section, for the purposes of this subpart, an attestation may be made by the application filer.

(2) The attestations specified in § 155.310(d)(2)(ii) and § 155.315(f)(4)(ii) must be provided by the tax filer.

(d) *Reasonably compatible.* For purposes of this subpart, the Exchange must consider information obtained through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions.

§ 155.302 Options for conducting eligibility determinations.

(a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—

(1) Directly, through contracting arrangements in accordance with § 155.110(a), or as a State-based Exchange on the Federal platform through a Federal platform agreement under which HHS carries out eligibility determinations and other requirements contained within this subpart; or

(2) Through a combination of the approach described in paragraph (a)(1) of this section and one or both of the options described in paragraph (b) or (c) of this section, subject to the standards in paragraph (d) of this section.

(b) *Medicaid and CHIP.* Notwithstanding the requirements of this subpart, the Exchange may conduct an assessment of eligibility for Medicaid and CHIP, rather than an eligibility determination for Medicaid and CHIP, provided that—

(1) The Exchange makes such an assessment based on the applicable Medicaid and CHIP MAGI-based income standards and citizenship and immigration status, using verification rules and procedures consistent with 42 CFR parts 435 and 457, without regard to how such standards are implemented by the State Medicaid and CHIP agencies.

(2) Notices and other activities required in connection with an eligibility determination for Medicaid or CHIP are performed by the Exchange consistent with the standards identified in this subpart or the State Medicaid or CHIP agency consistent with applicable law.

(3) *Applicants found potentially eligible for Medicaid or CHIP.* When the Exchange assesses an applicant as potentially eligible for Medicaid or CHIP consistent with the standards in paragraph (b)(1) of this section, the Exchange transmits all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or

verified by the Exchange to the State Medicaid agency or CHIP agency via secure electronic interface, promptly and without undue delay.

(4) *Applicants not found potentially eligible for Medicaid and CHIP*. (i) If the Exchange conducts an assessment in accordance with paragraph (b) of this section and finds that an applicant is not potentially eligible for Medicaid or CHIP based on the applicable Medicaid and CHIP MAGI-based income standards, the Exchange must consider the applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions and must notify such applicant, and provide him or her with the opportunity to—

(A) Withdraw his or her application for Medicaid and CHIP, unless the Exchange has assessed the applicant as potentially eligible for Medicaid based on factors not otherwise considered in this subpart, in accordance with § 155.345(b), and provided that the application will not be considered withdrawn if he or she appeals his or her eligibility determination for advance payments of the premium tax credit or cost-sharing reductions and the appeals entity described in § 155.500(a) finds that the individual is potentially eligible for Medicaid or CHIP; or

(B) Request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies.

(ii) To the extent that an applicant described in paragraph (b)(4)(i) of this section requests a full determination of eligibility for Medicaid and CHIP, the Exchange must—

(A) Transmit all information provided as a part of the application, update, or renewal that initiated the assessment, and any information obtained or verified by the Exchange to the State Medicaid agency and CHIP agency via secure electronic interface, promptly and without undue delay; and

(B) Consider such an applicant as ineligible for Medicaid and CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notifies the Exchange that the applicant is eligible for Medicaid or CHIP.

(5) The Exchange and the Exchange appeals entity adheres to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

(6) The Exchange and the State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP, and provide a copy of such agreement to HHS upon request.

(c) *Advance payments of the premium tax credit and cost-sharing reductions.* Notwithstanding the requirements of this subpart, the Exchange may implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS, provided that—

(1) Verifications, notices, and other activities required in connection with an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions are performed by the Exchange in accordance with the standards identified in this subpart or by HHS in accordance with the agreement described in paragraph (c)(4) of this section;

(2) The Exchange transmits all information provided as a part of the application, update, or renewal that initiated the eligibility determination, and any information obtained or verified by the Exchange, to HHS via secure electronic interface, promptly and without undue delay;

(3) The Exchange adheres to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions made by HHS; and

(4) The Exchange and HHS enter into an agreement specifying their respective responsibilities in connection with eligibility

determinations for advance payments of the premium tax credit and cost-sharing reductions.

(d) *Standards.* To the extent that assessments of eligibility for Medicaid and CHIP based on MAGI or eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) or (c) of this section, the Exchange must ensure that—

(1) Eligibility processes for all insurance affordability programs are streamlined and coordinated across HHS, the Exchange, the State Medicaid agency, and the State CHIP agency, as applicable;

(2) Such arrangement does not increase administrative costs and burdens on applicants, enrollees, beneficiaries, or application filers, or increase delay; and

(3) Applicable requirements under 45 CFR 155.260, 155.270, and 155.315(i), and section 6103 of the Code for the confidentiality, disclosure, maintenance, and use of information are met.

§ 155.305 Eligibility standards.

(a) *Eligibility for enrollment in a QHP through the Exchange.* The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange if he or she meets the following requirements:

(1) *Citizenship, status as a national, or lawful presence.* Is a citizen or national of the United States, or is a non-citizen who is lawfully present in the United States, and is reasonably expected to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought;

(2) *Incarceration.* Is not incarcerated, other than incarceration pending the disposition of charges; and

(3) *Residency.* Meets the applicable residency standard identified in this paragraph (a)(3).

(i) For an individual who is age 21 and over, is not living in an institution as defined in 42 CFR 435.403(b), is capable of indicating intent, and is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the service area of the Exchange of the individual is the service areas of the Exchange in which he or she is living and—

(A) Intends to reside, including without a fixed address; or

(B) Has entered with a job commitment or is seeking employment (whether or not currently employed).

(ii) For an individual who is under the age of 21, is not living in an institution as defined in 42 CFR 435.403(b), is not eligible for Medicaid based on receipt of assistance under title IV–E of the Social Security Act as addressed in 42 CFR 435.403(g), is not emancipated, is not receiving an optional State supplementary payment as addressed in 42 CFR 435.403(f), the Exchange service area of the individual—

(A) Is the service area of the Exchange in which he or she resides, including without a fixed address; or

(B) Is the service area of the Exchange of a parent or caretaker, established in accordance with paragraph (a)(3)(i) of this section, with whom the individual resides.

(iii) *Other special circumstances.* In the case of an individual who is not described in paragraphs (a)(3)(i) or (ii) of this section, the Exchange must apply the residency requirements described in 42 CFR 435.403 with respect to the service area of the Exchange.

(iv) *Special rule for tax households with members in multiple Exchange service areas.* (A) Except as specified in paragraph (a)(3)(iv)(B) of this section if all of the members of a tax household are not within the same Exchange service area, in accordance with the applicable standards in paragraphs (a)(3)(i), (ii), and (iii) of this section, any member of the tax household may enroll in a QHP through any of the Exchanges for which

one of the tax filers meets the residency standard.

(B) If both spouses in a tax household enroll in a QHP through the same Exchange, a tax dependent may only enroll in a QHP through that Exchange, or through the Exchange that services the area in which the dependent meets a residency standard described in paragraphs (a)(3)(i), (ii), or (iii) of this section.

(v) *Temporary absence.* The Exchange may not deny or terminate an individual's eligibility for enrollment in a QHP through the Exchange if the individual meets the standards in paragraph (a)(3) of this section but for a temporary absence from the service area of the Exchange and intends to return when the purpose of the absence has been accomplished.

(b) *Eligibility for QHP enrollment periods.* The Exchange must determine an applicant eligible for an enrollment period if he or she meets the criteria for an enrollment period, as specified in §§ 155.410 and 155.420.

(c) *Eligibility for Medicaid.* The Exchange must determine an applicant eligible for Medicaid if he or she meets the non-financial eligibility criteria for Medicaid for populations whose eligibility is based on MAGI-based income, as certified by the Medicaid agency in accordance with 42 CFR 435.1200(b)(2), has a household income, as defined in 42 CFR 435.603(d), that is at or below the applicable Medicaid MAGI-based income standard as defined in 42 CFR 435.911(b)(1) and—

(1) Is a pregnant woman, as defined in the Medicaid State Plan in accordance with 42 CFR 435.4;

(2) Is under age 19;

(3) Is a parent or caretaker relative of a dependent child, as defined in the Medicaid State plan in accordance with 42 CFR 435.4; or

(4) Is not described in paragraph (c)(1), (2), or (3) of this section, is under age 65 and is not entitled to or enrolled for benefits under part A of title XVIII of the Social Security Act, or enrolled for benefits under part B of title XVIII of the Social Security Act.

(d) *Eligibility for CHIP.* The Exchange must determine an applicant eligible for CHIP if he or she meets the requirements of 42 CFR 457.310 through 457.320 and has a household income, as defined in 42 CFR 435.603(d), at or below the applicable CHIP MAGI-based income standard.

(e) *Eligibility for BHP.* If a BHP is operating in the service area of the Exchange, the Exchange must determine an applicant eligible for the BHP if he or she meets the requirements specified in section 1331(e) of the Affordable Care Act and regulations implementing that section.

(f) *Eligibility for advance payments of the premium tax credit.* (1) *In general.* The Exchange must determine a tax filer eligible for advance payments of the premium tax credit if the Exchange determines that—

(i) He or she is expected to have a household income that will qualify the tax filer as an applicable taxpayer according to 26 CFR 1.36B–2(b) for the benefit year for which coverage is requested; and

(ii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section; and

(B) Is not eligible for minimum essential coverage for the full calendar month for which advance payments of the premium tax credit would be paid, with the exception of coverage in the individual market, in accordance with 26 CFR 1.36B–2(a)(2) and (c).

(2) *Special rule for non-citizens who are lawfully present and who are ineligible for Medicaid by reason of immigration status.* The Exchange must determine a tax filer eligible for advance

payments of the premium tax credit if the Exchange determines that—

(i) He or she meets the requirements specified in paragraph (f)(1) of this section, except for paragraph (f)(1)(i);

(ii) He or she is expected to have a household income, as defined in 26 CFR 1.36B–1(e) of less than 100 percent of the FPL for the benefit year for which coverage is requested; and

(iii) One or more applicants for whom the tax filer expects to claim a personal exemption deduction on his or her tax return for the benefit year, including the tax filer and his or her spouse, is a noncitizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with 26 CFR 1.36B–2(b)(5).

(3) *Enrollment required.* The Exchange may provide advance payments of the premium tax credit on behalf of a tax filer only if one or more applicants for whom the tax filer attests that he or she expects to claim a personal exemption deduction for the benefit year, including the tax filer and his or her spouse, is enrolled in a QHP that is not a catastrophic plan, through the Exchange.

(4) *Compliance with filing requirement.* The Exchange may not determine a tax filer eligible for advance payments of the premium tax credit (APTC) if HHS notifies the Exchange as part of the process described in § 155.320(c)(3) that APTC payments were made on behalf of either the tax filer or spouse, if the tax filer is a married couple, for two consecutive years for which tax data would be utilized for verification of household income and family size in accordance with § 155.320(c)(1)(i), and the tax filer or the tax filer's spouse did not comply with the requirement to file an income tax return for that year and for the previous year as required by 26 U.S.C. 6011, 6012, and in 26 CFR chapter I, and reconcile APTC for that period.

(5) *Calculation of advance payments of the premium tax credit.* The Exchange must calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B–3 and § 155.340(i) of this subpart.

(6) *Collection of Social Security numbers.* The Exchange must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size.

(g) *Eligibility for cost-sharing reductions.* (1) *Eligibility criteria.* (i) The Exchange must determine an applicant eligible for cost-sharing reductions if he or she—

(A) Meets the requirements for eligibility for enrollment in a QHP through the Exchange, as specified in paragraph (a) of this section;

(B) Meets the requirements for advance payments of the premium tax credit, as specified in paragraph (f) of this section; and

(C) Is expected to have a household income that does not exceed 250 percent of the FPL, for the benefit year for which coverage is requested.

(ii) The Exchange may only provide cost-sharing reductions to an enrollee who is not an Indian if he or she is enrolled through the Exchange in a silver-level QHP, as defined by section 1302(d)(1)(B) of the Affordable Care Act.

(2) *Eligibility categories.* The Exchange must use the following eligibility categories for cost-sharing reductions when making eligibility determinations under this section—

(i) An individual who is expected to have a household income greater than or equal to 100 percent of the FPL and less than or equal to 150 percent of the FPL for the benefit year for which coverage is requested, or for an individual who is eligible for advance payments of the premium tax credit under paragraph (f)(2) of this section, a household income less than 100 percent of the FPL for

the benefit year for which coverage is requested;

(ii) An individual is expected to have a household income greater than 150 percent of the FPL and less than or equal to 200 percent of the FPL for the benefit year for which coverage is requested; and

(iii) An individual who is expected to have a household income greater than 200 percent of the FPL and less than or equal to 250 percent of the FPL for the benefit year for which coverage is requested.

(3) *Special rule for family policies.* To the extent that an enrollment in a QHP in the individual market offered through an Exchange under a single policy covers two or more individuals who, if they were to enroll in separate individual policies would be eligible for different cost sharing, the Exchange must deem the individuals under such policy to be collectively eligible only for the category of eligibility last listed below for which all the individuals covered by the policy would be eligible:

(i) Individuals not eligible for changes to cost sharing;

(ii) Individuals described in § 155.350(b) (the special cost-sharing rule for Indians regardless of income);

(iii) Individuals described in paragraph (g)(2)(iii) of this section;

(iv) Individuals described in paragraph (g)(2)(ii) of this section;

(v) Individuals described in paragraph (g)(2)(i) of this section; and

(vi) Individuals described in § 155.350(a) (the cost-sharing rule for Indians with household incomes under 300 percent of the FPL).

(4) For the purposes of paragraph (g) of this section, "household income" means household income as defined in section 36B(d)(2) of the Code.

(h) *Eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.* The Exchange must determine an applicant eligible for enrollment in a QHP through the Exchange in a QHP that is a catastrophic plan as defined by section 1302(e) of the Affordable Care Act, if he or she has met the requirements for eligibility for enrollment in a QHP through the Exchange, in accordance with § 155.305(a), and either—

(1) Has not attained the age of 30 before the beginning of the plan year; or

(2) Has a certification in effect for any plan year that he or she is exempt from the requirement to maintain minimum essential coverage under section 5000A of the Code by reason of—

(i) Section 5000A(e)(1) of the Code (relating to individuals without affordable coverage); or

(ii) Section 5000A(e)(5) of the Code (relating to individuals with hardships).

§ 155.310 Eligibility process.

(a) *Application.* (1) *Accepting applications.* The Exchange must accept applications from individuals in the form and manner specified in § 155.405.

(2) *Information collection from non-applicants.* The Exchange may not request information regarding citizenship, status as a national, or immigration status for an individual who is not seeking coverage for himself or herself on any application or supplemental form.

(3) *Collection of Social Security numbers.* (i) The Exchange must require an applicant who has a Social Security number to provide such number to the Exchange.

(ii) The Exchange may not require an individual who is not seeking coverage for himself or herself to provide a Social Security number, except as specified in § 155.305(f)(6).

(b) *Applicant choice for Exchange to determine eligibility for insurance affordability programs.* The Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange; however, the Exchange may

not permit an applicant to request an eligibility determination for less than all insurance affordability programs.

(c) *Timing.* The Exchange must accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during the year.

(d) *Determination of eligibility.* (1) The Exchange must determine an applicant's eligibility, in accordance with the standards specified in § 155.305.

(2) *Special rules relating to advance payments of the premium tax credit.* (i) The Exchange must permit an enrollee to accept less than the full amount of advance payments of the premium tax credit for which he or she is determined eligible.

(ii) The Exchange may authorize advance payments of the premium tax credit on behalf of a tax filer only if the Exchange first obtains necessary attestations from the tax filer regarding advance payments of the premium tax credit, including, but not limited to attestations that—

(A) He or she will file an income tax return for the benefit year, in accordance with 26 U.S.C. 6011, 6012, and implementing regulations;

(B) If married (within the meaning of 26 CFR 1.7703–1), he or she will file a joint tax return for the benefit year;

(C) No other taxpayer will be able to claim him or her as a tax dependent for the benefit year; and

(D) He or she will claim a personal exemption deduction on his or her tax return for the applicants identified as members of his or her family, including the tax filer and his or her spouse, in accordance with § 155.320(c)(3)(i).

(3) *Special rule relating to Medicaid and CHIP.* To the extent that the Exchange determines an applicant eligible for Medicaid or CHIP, the Exchange must notify the State Medicaid or CHIP agency and transmit all information from the records of the Exchange to the State Medicaid or CHIP agency, promptly and without undue delay, that is necessary for such agency to provide the applicant with coverage.

(e) *Timeliness standards.* (1) The Exchange must determine eligibility promptly and without undue delay.

(2) The Exchange must assess the timeliness of eligibility determinations based on the period from the date of application or transfer from an agency administering an insurance affordability program to the date the Exchange notifies the applicant of its decision or the date the Exchange transfers the application to another agency administering an insurance affordability program, when applicable.

(f) *Effective dates for eligibility.* Upon making an eligibility determination, the Exchange must implement the eligibility determination under this section for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions as follows—

(1) For an initial eligibility determination, in accordance with the dates specified in § 155.410(c) and (f) and § 155.420(b), as applicable,

(2) For a redetermination, in accordance with the dates specified in § 155.330(f) and § 155.335(i), as applicable.

(g) *Notification of eligibility determination.* The Exchange must provide timely written notice to an applicant of any eligibility determination made in accordance with this subpart.

(h) *Notice of an employee's receipt of advance payments of the premium tax credit and cost-sharing reductions to an employer.* The Exchange must notify an employer that an employee has been determined eligible for advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange within a reasonable timeframe following a determination that the employee is eligible for advance payments of the premium tax credit and cost-sharing reductions in accordance with § 155.305(g) or § 155.350(a) and enrollment by the employee in a qualified health plan through the Exchange. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible [*sic*—for] advance payments of the premium tax credit and cost-sharing reductions and has enrolled in a qualified health plan through the Exchange;

(3) Indicate that, if the employer has 50 or more full-time employees, the employer may be liable for the payment assessed under section 4980H of the Code; and

(4) Notify the employer of the right to appeal the determination.

(i) *Certification program for employers.* As part of its determination of whether an employer has a liability under section 4980H of the Code, the Internal Revenue Service will adopt methods to certify to an employer that one or more employees has enrolled for one or more months during a year in a QHP for which a premium tax credit or cost-sharing reduction is allowed or paid.

(j) *Duration of eligibility determinations without enrollment.* To the extent that an applicant who is determined eligible for enrollment in a QHP through the Exchange does not select a QHP within his or her enrollment period, or is not eligible for an enrollment period, in accordance with subpart E, and seeks a new enrollment period prior to the date on which his or her eligibility is redetermined in accordance with § 155.335, the Exchange must require the applicant to attest as to whether information affecting his or her eligibility has changed since his or her most recent eligibility determination before determining his or her eligibility for a special enrollment period, and must process any changes reported in accordance with the procedures specified in § 155.330.

(k) *Incomplete application.* If an application filer submits an application that does not include sufficient information for the Exchange to conduct an eligibility determination for enrollment in a QHP through the Exchange or for insurance affordability programs, if applicable, the Exchange must—

(1) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and

(2) Provide the applicant with a period of no less than 10 days and no more than 90 days from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange.

(3) During the period described in paragraph (k)(2) of this section, the Exchange must not proceed with an applicant's eligibility determination or provide advance payments of the premium tax credit or cost-sharing reductions, unless an application filer has provided sufficient information to determine his or her eligibility for enrollment in a QHP through the Exchange, in which case the Exchange must make such a determination for enrollment in a QHP.

§ 155.315 Verification process related to eligibility for enrollment in a QHP through the Exchange.

(a) *General requirement.* Unless a request for modification is granted in accordance with paragraph (h) of this section, the Exchange must verify or obtain information as provided in this section in order to determine that an applicant is eligible for enrollment in a QHP through the Exchange.

(b) *Validation of Social Security number.* (1) For any individual who provides his or her Social Security number to the Exchange, the Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

(c) *Verification of citizenship, status as a national, or lawful presence.* (1) *Verification with records from the Social Security Administration.* For an applicant who attests to citizenship and has a Social Security number, the Exchange must transmit the applicant's Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) *Verification with the records of the Department of Homeland Security.* For an applicant who has documentation that can be verified through the Department of Homeland Security and who attests to lawful presence, or who attests to citizenship and for whom the Exchange cannot substantiate a claim of citizenship through the Social Security Administration, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS, which will submit necessary information to the Department of Homeland Security for verification.

(3) *Inconsistencies and inability to verify information.* For an applicant who attests to citizenship, status as a national, or lawful presence, and for whom the Exchange cannot verify such attestation through the Social Security Administration or the Department of Homeland Security, the Exchange must follow the procedures specified in paragraph (f) of this section, except that the Exchange must provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration or the Department of Homeland Security, as applicable. The date on which the notice is received means 5 days after the date on the notice, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period.

(d) *Verification of residency.* The Exchange must verify an applicant's attestation that he or she meets the standards of § 155.305(a)(3) as follows—

(1) Except as provided in paragraphs (d)(3) and (4) of this section, accept his or her attestation without further verification; or

(2) Examine electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(3) If information provided by an applicant regarding residency is not reasonably compatible with other information provided by the individual or in the records of the Exchange the Exchange must examine information in data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate.

(4) If the information in such data sources is not reasonably compatible with the information provided by the applicant, the Exchange must follow the procedures specified in paragraph (f) of this section. Evidence of immigration status may not be used to determine that an applicant is not a resident of the Exchange service area.

(e) *Verification of incarceration status.* The Exchange must verify an applicant's attestation that he or she meets the requirements of § 155.305(a)(2) by—

(1) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current, accurate, and offer less administrative complexity than paper verification; or

(2) Except as provided in paragraph (e)(3) of this section, if an approved data source is unavailable, accepting his or her attestation without further verification.

(3) To the extent that an applicant's attestation is not reasonably compatible with information from approved data sources described in paragraph (e)(1) of this section or other information provided by the applicant or in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

(f) *Inconsistencies.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange

cannot verify information required to determine eligibility for enrollment in a QHP through the Exchange, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination are not included in such data sources or when electronic data from IRS, DHS, or SSA is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange:

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in paragraph (f)(1) of this section, must—

(i) Provide notice to the applicant regarding the inconsistency; and

(ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (f)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in § 155.405(c), except for by telephone through a call center, or otherwise resolve the inconsistency.

(3) May extend the period described in paragraph (f)(2)(ii) of this section for an applicant if the applicant demonstrates that a good faith effort has been made to obtain the required documentation during the period.

(4) During the periods described in paragraphs (f)(1) and (f)(2)(ii) of this section, must:

(i) Proceed with all other elements of eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified; and

(ii) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant within this period who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation.

(5) If, after the period described in paragraph (f)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart, unless such applicant qualifies for the exception provided under paragraph (g) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), including notice that the Exchange is unable to verify the attestation.

(6) When electronic data to support the verifications specified in § 155.315(d) or § 155.320(b) is required but it is not reasonably expected that data sources will be available within 1 day of the initial request to the data source, the Exchange must accept the applicant's attestation regarding the factor of eligibility for which the unavailable data source is relevant.

(7) Must extend the period described in paragraph (f)(2)(ii) of this section by a period of 60 days for an applicant if the applicant is required to present satisfactory documentary evidence to verify household income.

(g) *Exception for special circumstances.* For an applicant who does not have documentation with which to resolve the inconsistency through the process described in paragraph (f)(2) of this section because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, with the exception of an inconsistency related to citizenship or immigration status, the Exchange must provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.

(h) *Flexibility in information collection and verification.* HHS may approve an Exchange Blueprint in accordance with § 155.105(d) or a significant change to the Exchange Blueprint in accordance with § 155.105(e) to modify the methods to be used for collection of information and verification of information as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable requirements under § 155.260, § 155.270, paragraph (i) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

(i) *Applicant information.* The Exchange must not require an applicant to provide information beyond the minimum necessary to support the eligibility and enrollment processes of the Exchange, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, described in this subpart.

(j) *Verification related to eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan.* The Exchange must verify an applicant's attestation that he or she meets the requirements of § 155.305(h) by—

(1) Verifying the applicant's attestation of age as follows—

(i) Except as provided in paragraph (j)(1)(iii) of this section, accepting his or her attestation without further verification; or

(ii) Examining electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently current and accurate, and minimize administrative costs and burdens.

(iii) If information regarding age is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must examine information in data sources that are available to the Exchange and which have been approved by HHS for this purpose based on evidence showing that such data sources are sufficiently current and accurate.

(2) Verifying that an applicant has a certification of exemption in effect as described in § 155.305(h)(2).

(3) To the extent that the Exchange is unable to verify the information required to determine eligibility for enrollment through the Exchange in a QHP that is a catastrophic plan as described in paragraphs (j)(1) and (2) of this section, the Exchange must follow the procedures specified in § 155.315(f), except for § 155.315(f)(4).

§ 155.320 Verification process related to eligibility for insurance affordability programs.

(a) *General requirements.* (1) The Exchange must verify information in accordance with this section only for an applicant or tax filer who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b).

(2) Unless a request for modification is granted in accordance with § 155.315(h), the Exchange must verify or obtain information in accordance with this section before making an eligibility determination for insurance affordability programs, and must use such information in such determination.

(b) *Verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.* (1)(i) The Exchange must verify whether an applicant is eligible for minimum essential coverage other than through an eligible employer-sponsored plan, Medicaid, CHIP, or the BHP, using information obtained by transmitting identifying information specified by HHS to HHS for verification purposes.

(ii) The Exchange must verify whether an applicant has already been determined eligible for coverage through Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, within the State or States in which the Exchange operates using information obtained from the agencies administering such programs.

(2) Consistent with § 164.512(k)(6)(i) of this subchapter, the disclosure to HHS of information regarding eligibility for and enrollment in a health plan, which may be considered protected health information, as that term is defined in § 160.103 of this subchapter, is expressly authorized, for the purposes of verification of applicant eligibility for minimum essential coverage as part of the eligibility determination process for advance payments of the premium tax credit or cost-sharing reductions.

(c) *Verification of household income and family/household size.* (1) *Data.* (i) *Data regarding annual household income.* (A) For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B–1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number, the Exchange must request tax return data regarding MAGI and family size from the Secretary of the Treasury and data regarding Social security benefits described in 26 CFR 1.36B–1(e)(2)(iii) from the Commissioner of Social Security by transmitting identifying information specified by HHS to HHS.

(B) If the identifying information for one or more individuals does not match a tax record on file with the Secretary of the Treasury that may be disclosed in accordance with section 6103(l)(21) of the Code and its accompanying regulations, the Exchange must proceed in accordance with § 155.315(f)(1).

(ii) *Data regarding MAGI-based income.* For all individuals whose income is counted in calculating a tax filer's household income, as defined in 26 CFR 1.36B–1(e), or an applicant's household income, calculated in accordance with 42 CFR 435.603(d), the Exchange must request data regarding MAGI-based income in accordance with 42 CFR 435.948(a).

(2) *Verification process for Medicaid and CHIP.* (i) *Household size.* (A) The Exchange must verify household size in accordance with 42 CFR 435.945(a) or through other reasonable verification procedures consistent with the requirements in 42 CFR 435.952.

(B) The Exchange must verify the information in paragraph (c)(2)(i)(A) of this section by accepting an applicant's attestation without further verification, unless the Exchange finds that an applicant's attestation to the individuals that comprise his or her household for Medicaid and CHIP is not reasonably compatible with other information provided by the application filer for the applicant or in the records of the Exchange, in which case the Exchange must utilize data obtained through electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in 42 CFR 435.952.

(ii) *Verification process for MAGI-based household income.* The Exchange must verify MAGI-based income, within the meaning of 42 CFR 435.603(d), for the household described in paragraph (c)(2)(i) in accordance with the procedures specified in Medicaid regulations 42 CFR 435.945, 42 CFR 435.948, and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380.

(3) Verification process for advance payments of the premium tax credit and cost-sharing reductions. (i) Family size.

(A) The Exchange must require an applicant to attest to the individuals that comprise a tax filer's family for advance payments of the premium tax credit and cost-sharing reductions.

(B) To the extent that the applicant attests that the information described in paragraph (c)(1)(i) of this section represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the family size data in paragraph (c)(1)(i) of this section.

(C) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must verify the tax filer's family size for advance payments of the premium tax credit and cost-sharing reductions by accepting an applicant's attestation without further verification, except as specified in paragraph (c)(3)(i)(D) of this section.

(D) If the Exchange finds that an applicant's attestation of a tax filer's family size is not reasonably compatible with other information provided by the application filer for the family or in the records of the Exchange, with the exception of the data described in paragraph (c)(1)(i) of this section, the Exchange must utilize data obtained through other electronic data sources to verify the attestation. If such data sources are unavailable or information in such data sources is not reasonably compatible with the applicant's attestation, the Exchange must request additional documentation to support the attestation within the procedures specified in § 155.315(f).

(E) The Exchange must verify that neither advance payments of the premium tax credit nor cost-sharing reductions are being provided on behalf of an individual using information obtained by transmitting identifying information specified by HHS to HHS.

(ii) *Basic verification process for annual household income.* (A) The Exchange must compute annual household income for the family described in paragraph (c)(3)(i)(A) of this section based on the data described in paragraph (c)(1)(i) of this section;

(B) The Exchange must require the applicant to attest regarding a tax filer's projected annual household income;

(C) To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(ii)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(ii)(A) of this section.

(D) To the extent that the data described in paragraph (c)(1)(i) of this section is unavailable, or an applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so it does not represent an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must require the applicant to attest to the tax filer's projected household income for the benefit year for which coverage is requested.

(iii) *Verification process for changes in household income.* (A) Except as specified in paragraph (c)(3)(iii)(B) and (C) of this section, if an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(ii)(A) of this section for the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation regarding a tax filer's annual household income without further verification.

(B) If data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section indicate that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange must

proceed in accordance with § 155.315(f)(1) through (4).

(C) If other information provided by the application filer indicates that a tax filer's projected annual household income is in excess of his or her attestation by a significant amount, the Exchange must utilize data available to the Exchange in accordance with paragraph (c)(1)(ii) of this section to verify the attestation. If such data is unavailable or are not reasonably compatible with the applicant's attestation, the Exchange must proceed in accordance with § 155.315(f)(1) through (4).

(D) [*Reserved*]

(E) If, at the conclusion of the period specified in § 155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and implement such determination in accordance with the effective dates specified in § 155.330(f).

(F) If, at the conclusion of the period specified in § 155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in § 155.330(f).

(iv) *Eligibility for alternate verification process for decreases in annual household income and situations in which tax return data is unavailable.* The Exchange must determine a tax filer's annual household income for advance payments of the premium tax credit and cost-sharing reductions based on the alternate verification procedures described in paragraph (c)(3)(v) of this section, if an applicant attests to projected annual household income in accordance with paragraph (c)(3)(ii)(B) of this section, the tax filer does not meet the criteria specified in paragraph (c)(3)(iii) of this section, the applicants in the tax filer's family have not established MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section that is within the applicable Medicaid or CHIP MAGI-based income standard, and one of the following conditions is met—

(A) The Secretary of the Treasury does not have tax return data that may be disclosed under section 6103(l)(21) of the Code for the tax filer that is at least as recent as the calendar year two years prior to the calendar year for which advance payments of the premium tax credit or cost-sharing reductions would be effective;

(B) The applicant attests that the tax filer's applicable family size has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage, or the members of the tax filer's family have changed or are reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage;

(C) The applicant attests that a change in circumstances has occurred or is reasonably expected to occur, and so the tax filer's annual household income has decreased or is reasonably expected to decrease from the data described in paragraph (c)(1)(i) of this section for the benefit year for which the applicants in his or her family are requesting coverage;

(D) The applicant attests that the tax filer's filing status has changed or is reasonably expected to change for the benefit year for which the applicants in his or her family are requesting coverage; or

(E) An applicant in the tax filer's family has filed an application for unemployment benefits.

(v) *Alternate verification process.* If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is no more than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, the Exchange must accept the applicant's attestation without further verification.

(vi) *Alternate verification process for decreases in annual household income estimates and for situations in which tax return data is unavailable.* If a tax filer qualifies for an alternate verification process based on the requirements specified in paragraph (c)(3)(iv) of this section and the applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than a reasonable threshold below the annual household income computed in accordance with paragraph (c)(3)(ii)(A) of this section, or if data described in paragraph (c)(1)(i) of this section is unavailable, the Exchange must attempt to verify the applicant's attestation of the tax filer's projected annual household income by following the procedures specified in paragraph (c)(3)(vi)(A) through (G) of this section. For the purposes of this paragraph (c)(3)(vi), a reasonable threshold is established by the Exchange in guidance and approved by HHS, but must not be less than 10 percent, and can also include a threshold dollar amount. The Exchange's threshold is subject to approval by HHS.

(A) *Data.* The Exchange must annualize data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section, and obtain any data available from other electronic data sources that have been approved by HHS, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification.

(B) *Eligibility.* To the extent that the applicant's attestation indicates that the information described in paragraph (c)(3)(vi)(A) of this section represents an accurate projection of the tax filer's household income for the benefit year for which coverage is requested, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the household income data in paragraph (c)(3)(vi)(A) of this section.

(C) *Increases in annual household income.* If an applicant's attestation, in accordance with paragraph (c)(3)(ii)(B) of this section, indicates that a tax filer's annual household income has increased or is reasonably expected to increase from the data described in paragraph (c)(3)(vi)(A) of this section to the benefit year for which the applicant(s) in the tax filer's family are requesting coverage and the Exchange has not verified the applicant's MAGI-based income through the process specified in paragraph (c)(2)(ii) of this section to be within the applicable Medicaid or CHIP MAGI-based income standard, the Exchange must accept the applicant's attestation for the tax filer's family without further verification, unless:

(*1*) The Exchange finds that an applicant's attestation of a tax filer's annual household income is not reasonably compatible with other information provided by the application filer, or

(*2*) [*Reserved*]

(D) *Decreases in annual household income and situations in which electronic data is unavailable.* If electronic data are unavailable or an applicant's attestation to projected annual household income, as described in paragraph (c)(3)(ii)(B) of this section, is more than a reasonable threshold below the annual household income as computed using data sources

described in paragraphs (c)(3)(vi)(A) of this section, the Exchange must follow the procedures specified in § 155.315(f)(1) through (4). The reasonable threshold used under this paragraph must be equal to the reasonable threshold established in accordance with paragraph (c)(3)(vi) of this section.

(E) If, following the 90-day period described in paragraph (c)(3)(vi)(D) of this section, an applicant has not responded to a request for additional information from the Exchange and the data sources specified in paragraph (c)(1) of this section indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange must not provide the applicant with eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP or the BHP, if a BHP is operating in the service area of the Exchange.

(F) If, at the conclusion of the period specified in § 155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information described in paragraph (c)(3)(ii)(A) of this section, notify the applicant of such determination in accordance with the notice requirements specified in § 155.310(g), and implement such determination in accordance with the effective dates specified in § 155.330(f).

(G) If, at the conclusion of the period specified in § 155.315(f)(2)(ii), the Exchange remains unable to verify the applicant's attestation for the tax filer and the information described in paragraph (c)(3)(ii)(A) of this section is unavailable, the Exchange must determine the tax filer ineligible for advance payments of the premium tax credit and cost-sharing reductions, notify the applicant of such determination in accordance with the notice requirement specified in § 155.310(g), and discontinue any advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in § 155.330(f).

(vii) For the purposes of paragraph (c)(3) of this section, ''household income'' means household income as specified in 26 CFR 1.36B–1(e).

(viii) For the purposes of paragraph (c)(3) of this section, "family size" means family size as specified in 26 CFR 1.36B–1(d).

(4) *Alternate procedures.* For any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii) of this section, the Exchange must follow the procedures specified in paragraph (d)(4)(i) of this section or, for benefit years 2016 through 2019, the Exchange may follow the procedures specified in paragraph (d)(4)(ii) of this section. For purposes of this paragraph (d)(4), the Exchange reasonably expects to obtain sufficient verification data for any benefit year when, for the benefit year, the Exchange is able to obtain data about enrollment in and eligibility for qualifying coverage in an eligible employer-sponsored plan from at least one electronic data source that is available to the Exchange and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraph (d)(2)(i) of this section.

(5) *Acceptance of attestation.* Notwithstanding any other requirement described in this paragraph (c) to the contrary, when the Exchange requests tax return data and family size from the Secretary of Treasury as described in paragraph (c)(1)(i)(A) of this section but no such data is returned for an applicant, the Exchange will accept that applicant's attestation of income and family size without further verification.

(d) *Verification related to enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan.* (1) *General requirement.* The Exchange must verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan or is eligible for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested.

(2) *Data.* The Exchange must—

(i) Obtain data about enrollment in and eligibility for an eligible employer-sponsored plan from any electronic data sources that are available to the Exchange and which have been approved by HHS, based on evidence showing that such data sources are sufficiently current, accurate, and minimize administrative burden.

(ii) Obtain any available data regarding enrollment in employer-sponsored coverage or eligibility for qualifying coverage in an eligible employer-sponsored plan based on federal employment by transmitting identifying information specified by HHS to HHS for HHS to provide the necessary verification using data obtained by HHS.

(iii) Obtain any available data from the SHOP that corresponds to the State in which the Exchange is operating.

(3) *Verification procedures.* (i) If an applicant's attestation is not reasonably compatible with the information obtained by the Exchange as specified in paragraphs (d)(2)(i) through (iii) of this section, other information provided by the application filer, or other information in the records of the Exchange, the Exchange must follow the procedures specified in § 155.315(f).

(ii) Except as specified in paragraph (d)(3)(i) or (d)(4)(i) of this section, the Exchange must accept an applicant's attestation regarding the verification specified in paragraph (d) of this section without further verification.

(4) *Alternate procedures.* For any benefit year for which it does not reasonably expect to obtain sufficient verification data as described in paragraphs (d)(2)(i) through (iii) of this section, the Exchange may follow the procedures specified in paragraph (d)(4)(i) of this section. For purposes of this paragraph (d)(4), the Exchange reasonably expects to obtain sufficient verification data for the benefit year when the Exchange is able to obtain data about enrollment in or eligibility for qualifying coverage in an eligible employer sponsored plan from at least one electronic data source that is available to the Exchange and that has been approved by HHS, based on evidence showing that the data source is sufficiently current, accurate, and minimizes administrative burden, as described under paragraphs (d)(2)(i) of this section.

(i) Based on the Exchange's assessment of risk for inappropriate payment of advance payments of the premium tax credit or cost-sharing reductions, implement a verification process that is reasonably designed to ensure the accuracy of the data and is based on the activities or methods used by an Exchange such as studies, research, and analysis of an Exchange's own enrollment data, for enrollment in or eligibility for qualifying coverage in an eligible employer sponsored plan, as appropriate.

(A) The Exchange must provide notice to the applicant if, as part of the verification process described under paragraph (d)(4)(i) of this section, the Exchange will be contacting any employer identified on the application for the applicant and the members of his or her family, as defined in 26 CFR 1.36B–1(d), to verify whether the applicant is enrolled in an eligible employer sponsored plan or is eligible for qualifying coverage in an eligible employer sponsored plan for the benefit year for which coverage is requested;

(B) Proceed with all other elements of the eligibility determination using the applicant's attestation, and provide eligibility for enrollment in a QHP to the extent that an applicant is otherwise qualified;

(C) Ensure that advance payments of the premium tax credit and cost-sharing reductions are provided on behalf of an applicant who is otherwise qualified for such payments and reductions, as described in § 155.305, if the tax filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit paid on his or her behalf are subject to reconciliation;

(D) If the Exchange receives any information from an employer relevant to the applicant's enrollment in an eligible

employer-sponsored plan or eligibility for qualifying coverage in an eligible employer-sponsored plan, the Exchange must determine the applicant's eligibility based on such information and in accordance with the effective dates specified in § 155.330(f), and if such information changes his or her eligibility determination, notify the applicant and his or her employer or employers of such determination in accordance with the notice requirements specified in § 155.310(g) and (h);

(E) To carry out the process described in paragraph (d)(4)(iii) of this section, the Exchange must only disclose an individual's information to an employer to the extent necessary for the employer to identify the employee.

(ii) [Reserved]

(e) *Additional verification related to immigration status for Medicaid and CHIP*. (1) For purposes of determining eligibility for Medicaid, the Exchange must verify whether an applicant who does not attest to being a citizen or a national has satisfactory immigration status to be eligible for Medicaid, as required by 42 CFR 435.406 and, if applicable under the State Medicaid plan, section 1903(v)(4) of the Act.

(2) For purposes of determining eligibility for CHIP, the Exchange must verify whether an applicant who does not attest to being a citizen or a national has satisfactory immigration status to be eligible for CHIP, in accordance with 42 CFR 457.320(b) and if applicable under the State Child Health Plan, section 2107(e)(1)(J) of the Act.

§ 155.330 Eligibility redetermination during a benefit year.

(a) *General requirement.* The Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange during the benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through the data matching described in paragraph (d) of this section.

(b) *Requirement for individuals to report changes.* (1) Except as specified in paragraphs (b)(2) and (3) of this section, the Exchange must require an enrollee to report any change with respect to the eligibility standards specified in § 155.305 within 30 days of such change.

(2) The Exchange must not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs.

(3) The Exchange may establish a reasonable threshold for changes in income, such that an enrollee who experiences a change in income that is below the threshold is not required to report such change.

(4) The Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2), except that the Exchange is permitted but not required to allow an enrollee, or an application filer, on behalf of the enrollee, to report changes via mail.

(c) *Verification of reported changes.* The Exchange must—

(1) Verify any information reported by an enrollee in accordance with the processes specified in §§ 155.315 and 155.320 prior to using such information in an eligibility redetermination; and

(2) Provide periodic electronic notifications regarding the requirements for reporting changes and an enrollee's opportunity to report any changes as described in paragraph (b)(3) of this section, to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive notifications under this paragraph (c)(2).

(d) *Periodic examination of data sources.* (1) *General requirement.* Subject to paragraph (d)(3) of this section, the Exchange must periodically examine available data sources described in §§ 155.315(b)(1) and 155.320(b) to identify the following changes:

(i) Death; and

(ii) For an enrollee on whose behalf advance payments of the premium tax credit or cost-sharing reductions are being provided, eligibility determinations for or enrollment in Medicare, Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange.

(2) *Flexibility.* The Exchange may make additional efforts to identify and act on changes that may affect an enrollee's eligibility for enrollment in a QHP through the Exchange or for insurance affordability programs, provided that such efforts—

(i) Would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that it would not undermine coordination with Medicaid and CHIP, and that applicable requirements under §§ 155.260, 155.270, 155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met; and

(ii) Comply with the standards specified in paragraph (e)(2) of this section.

(3) *Definition of periodically.* Beginning with the 2021 calendar year, the Exchange must perform the periodic examination of data sources described in paragraph (d)(1)(ii) of this section at least twice in a calendar year. State Exchanges that have implemented a fully integrated eligibility system with their respective State Medicaid programs, that have a single eligibility rules engine that uses MAGI to determine eligibility for advance payments of the premium tax credit, cost-sharing reductions, Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, will be deemed in compliance with the Medicaid/CHIP PDM requirements and, if applicable, BHP PDM requirements, in paragraphs (d)(1)(ii) and (d)(3) of this section.

(e) *Redetermination and notification of eligibility.* (1) *Enrollee-reported data.* If the Exchange verifies updated information reported by an enrollee, the Exchange must—

(i) Redetermine the enrollee's eligibility in accordance with the standards specified in § 155.305;

(ii) Notify the enrollee regarding the determination in accordance with the requirements specified in § 155.310(g); and

(iii) Notify the enrollee's employer, as applicable, in accordance with the requirements specified in § 155.310(h).

(2) *Data matching.* (i) Except as provided in paragraph (e)(2)(iii) of this section, if the Exchange identifies updated information regarding death, in accordance with paragraph (d)(1)(i) of this section, or regarding any factor of eligibility not regarding income, family size, or family composition, or tax filing status, the Exchange must—

(A) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information.

(B) Allow an enrollee 30 days from the date of the notice to notify the Exchange that such information is inaccurate.

(C) If the enrollee responds contesting the updated information, proceed in accordance with § 155.315(f) of this part.

(D) If the enrollee does not respond contesting the updated information within the 30-day period specified in paragraph (e)(2)(i)(B) of this section, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section, provided the enrollee has not directed the Exchange to terminate his or her coverage under such circumstances, in which case the Exchange will terminate the enrollee's coverage in accordance with § 155.430(b)(1)(ii), and provided the enrollee has not been determined to be deceased, in which case the Exchange will terminate the enrollee's coverage in accordance with § 155.430(d)(7).

(ii) If the Exchange identifies updated information regarding income, family size, or family composition, with the exception of information regarding death, the Exchange must—

(A) Follow procedures described in paragraph (e)(2)(i)(A) and (B) of this section; and

(B) If the enrollee responds confirming the updated information, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(C) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(i)(B) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(D) If the enrollee provides more up-to-date information, proceed in accordance with paragraph (c)(1) of this section.

(iii) If the Exchange identifies updated information that the tax filer for the enrollee's household or the tax filer's spouse did not comply with the requirements described in § 155.305(f)(4), the Exchange when redetermining and providing notification of eligibility for advance payments of the premium tax credit must:

(A) Follow the procedures specified in paragraph (e)(2)(i) of this section;

(B) Follow the procedures in guidance published by the Secretary; or

(C) Follow alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures facilitate continued enrollment in coverage with financial assistance for which the enrollee remains eligible, provide appropriate information about the process to the enrollee (including regarding any action by the enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections and safeguards for Federal tax information under section 6103 of the Internal Revenue Code with respect to the confidentiality, disclosure, maintenance, or use of such information.

(f) *Effective dates.* (1) Except as specified in paragraphs (f)(2) through (f)(5) of this section, the Exchange must implement changes—

(i) Resulting from a redetermination under this section on the first day of the month following the date of the notice described in paragraph (e)(1)(ii) of this section; or

(ii) Resulting from an appeal decision, on the date specified in the appeal decision; or

(iii) Affecting enrollment or premiums only, on the first day of the month following the date on which the Exchange is notified of the change;

(2) Except as specified in paragraphs (f)(3) through (5) of this section, the Exchange may determine a reasonable point in a month after which a change described in paragraph (f)(1) of this section will not be effective until the first day of the month after the month specified in paragraph (f)(1) of this section. Such reasonable point in a month must be no earlier than the 15th of the month.

(3) Except as specified in paragraphs (f)(4) and (5) of this section, the Exchange must implement a change described in paragraph (f)(1) of this section that results in a decreased amount of advance payments of the premium tax credit, or a change in the level of cost-sharing reductions, and for which the date of the notices described in paragraphs (f)(1)(i) and (ii) of this section, or the date on which the Exchange is notified in accordance with paragraph (f)(1)(iii) of this section is after the 15th of the month, on the first day of the month after the month specified in paragraph (f)(1) of this section.

(4) The Exchange must implement a change associated with the events described in § 155.420(b)(2)(i) and (ii) on the coverage effective dates described in § 155.420(b)(2)(i) and (ii), respectively.

(5) Notwithstanding paragraphs (f)(1) through (f)(4) of this section, the Exchange may provide the effective date of a change associated with the events described in § 155.420(d)(4), (d)(5), and (d)(9) based on the specific circumstances of each situation.

(g) *Recalculation of advance payments of the premium tax credit and cost-sharing reductions.* (1) When an eligibility redetermination in accordance with this section results in a change in the amount of advance payments of the premium tax credit for the benefit year, the Exchange must:

(i) Recalculate the amount of advance payments of the premium tax credit in such a manner as to account for any advance payments already made on behalf of the tax filer for the benefit year for which information is available to the Exchange, such that the recalculated advance payment amount is projected to result in total advance payments for the benefit year that correspond to the tax filer's total projected premium tax credit for the benefit year, calculated in accordance with 26 CFR 1.36B–3 (or, if less than zero, be set at zero); or

(ii) Recalculate advance payments of the premium tax credit using an alternate method that has been approved by the Secretary.

(2) When an eligibility redetermination in accordance with this section results in a change in cost-sharing reductions, the Exchange must determine an individual eligible for the category of cost-sharing reductions that corresponds to his or her expected annual household income for the benefit year (subject to the special rule for family policies set forth in § 155.305(g)(3))

§ 155.335 Annual eligibility redetermination.

(a) *General requirement.* (1) Except as specified in paragraphs (l) and (m) of this section, the Exchange must redetermine the eligibility of a qualified individual on an annual basis.

(2) The Exchange must conduct annual redeterminations required under paragraph (a)(1) of this section using one of the following:

(i) The procedures described in paragraphs (b) through (m) of this section;

(ii) Alternative procedures specified by the Secretary for the applicable benefit year; or

(iii) Alternative procedures approved by the Secretary based on a showing by the Exchange that the alternative procedures would facilitate continued enrollment in coverage for which the enrollee remains eligible, provide clear information about the process to the qualified individual or enrollee (including regarding any action by the qualified individual or enrollee necessary to obtain the most accurate redetermination of eligibility), and provide adequate program integrity protections.

(b) *Updated income and family size information.* In the case of a qualified individual who requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) of this part, the Exchange must request updated tax return information, if the qualified individual has authorized the request of such tax return information, data regarding Social Security benefits, and data regarding MAGI-based income as described in § 155.320(c)(1) of this part for use in the qualified individual's eligibility redetermination.

(c) *Notice to qualified individual.* The Exchange must provide a qualified individual with an annual redetermination notice including the following:

(1) [Reserved]

(2) [Reserved]

(3) The qualified individual's projected eligibility determination for the following year, after considering any updated information described in paragraph (b) of this section, including, if applicable, the amount of any advance payments of the premium tax credit and the level of any cost-sharing reductions or eligibility for Medicaid, CHIP or BHP.

(d) *Timing.* (1) For redeterminations under this section for coverage effective January 1, 2015, the Exchange must satisfy the notice provisions of paragraph (c) of this section and § 155.410(d) through a single, coordinated notice.

(2) For redeterminations under this section for coverage effective on or after January 1, 2017, the Exchange may send the notice specified in paragraph (c) of this section separately from the notice of annual open enrollment specified in § 155.410(d), provided that—

(i) The Exchange sends the notice specified in paragraph (c) of this section no earlier than the date of the notice of annual open enrollment specified in § 155.410(d); and

(ii) The timing of the notice specified in paragraph (c) of this section allows a reasonable amount of time for the enrollee to review the notice, provide a timely response, and for the Exchange to implement any changes in coverage elected during the annual open enrollment period.

(e) *Changes reported by qualified individuals.* Except as specified in paragraph (e)(1) of this section, the Exchange must require a qualified individual to report any change with respect to the eligibility standards specified in § 155.305 within 30 days of such change.

(1) The Exchange must not require a qualified individual who did not request an eligibility determination for insurance affordability programs to report changes that affect eligibility for insurance affordability programs.

(2) The Exchange must allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via the channels available for the submission of an application, as described in § 155.405(c)(2), except that the Exchange is permitted but not required to allow a qualified individual, or an application filer, on behalf of the qualified individual, to report changes via mail.

(f) *Verification of reported changes.* The Exchange must verify any information reported by a qualified individual under paragraph (e) of this section using the processes specified in § 155.315 and § 155.320, including the relevant provisions in those sections regarding inconsistencies, prior to using such information to determine eligibility.

(g) *Response to redetermination notice.* (1) The Exchange must require a qualified individual, or an application filer, on behalf of the qualified individual, to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that a qualified individual does not sign and return the notice described in paragraph (c) of this section within the 30-day period specified in paragraph (e) of this section, the Exchange must proceed in accordance with the procedures specified in paragraph (h)(1) of this section.

(h) *Redetermination and notification of eligibility.* (1) After the 30-day period specified in paragraph (e) of this section has elapsed, the Exchange must—

(i) Redetermine the qualified individual's eligibility in accordance with the standards specified in § 155.305 using the information provided to the qualified individual in the notice specified in paragraph (c) of this section, as supplemented with any information reported by the qualified individual and verified by the Exchange in accordance with paragraphs (e) and (f) of this section.

(ii) Notify the qualified individual in accordance with the requirements specified in § 155.310(g).

(iii) If applicable, notify the qualified individual employer, in accordance with the requirements specified in § 155.310(h).

(2) If a qualified individual reports a change for the information provided in the notice specified in paragraph (c) of this section that the Exchange has not verified as of the end of the 30-day period specified in paragraph (e) of this section, the Exchange must redetermine the qualified individual's eligibility after completing verification, as specified in paragraph (f) of this section.

(i) *Effective date of annual redetermination.* The Exchange must ensure that a redetermination under this section is effective on the first day of the coverage year following the year in which the Exchange provided the notice in paragraph (c) of this section, or in accordance with the rules specified in§ 155.330(f) regarding effective dates, whichever is later.

(j) *Re-enrollment.* If an enrollee remains eligible for enrollment in a QHP through the Exchange upon annual redetermination and—

(1) The product under which the QHP in which the enrollee is enrolled remains available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will renew the enrollee in a QHP under that product, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, or unless otherwise provided in paragraph (j)(1)(iii)(A) or (j)(4) of this section, as follows:

(i) The Exchange will re-enroll the enrollee in the same plan as the enrollee's current QHP, unless the current QHP is not available through the Exchange;

(ii) If the enrollee's current QHP is not available through the Exchange, the Exchange will re-enroll the enrollee in a QHP within the same product at the same metal level as the enrollee's current QHP that has the most similar network compared to the enrollee's current QHP;

(iii) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP at the same metal level as the enrollee's current QHP and—

(A) The enrollee's current QHP is a silver level plan, the Exchange will reenroll the enrollee in a silver level QHP under a different product offered by the same QHP issuer that is most similar to the enrollee's current product and that has the most similar network compared to the enrollee's current QHP. If no such silver level QHP is available for enrollment through the Exchange, the Exchange will re-enroll the enrollee in a QHP under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP; or

(B) The enrollee's current QHP is not a silver level plan, the Exchange will reenroll the enrollee in a QHP under the same product that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP; or

(iv) If the enrollee's current QHP is not available through the Exchange and the enrollee's product no longer includes a QHP that is at the same metal level as, or one metal level higher or lower than, the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered under the product in which the enrollee's current QHP is offered in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP.

(2) No plans under the product under which the QHP in which the enrollee is enrolled are available through the Exchange for renewal, consistent with § 147.106 of this subchapter, the Exchange will enroll the enrollee in a QHP under a different product offered by the same QHP issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows, except as provided in paragraph (j)(4) of this section.

(i) The Exchange will re-enroll the enrollee in a QHP at the same metal level as the enrollee's current QHP in the product offered by the same issuer that is the most similar to the enrollee's current product and that has the most similar network compared to the enrollee's current QHP;

(ii) If the issuer does not offer another QHP at the same metal level as the enrollee's current QHP, the Exchange will re-enroll the enrollee in a QHP that is one metal level higher or lower than the enrollee's current QHP and that has the most similar network compared to the enrollee's current QHP in the product offered by the same issuer through the Exchange that is the most similar to the enrollee's current product; or

(iii) If the issuer does not offer another QHP through the Exchange at the same metal level

as, or one metal level higher or lower than the enrollee's current QHP, the Exchange will re-enroll the enrollee in any other QHP offered by the same issuer in which the enrollee is eligible to enroll and that has the most similar network compared to the enrollee's current QHP in the product that is most similar to the enrollee's current product.

(3) No QHPs from the same issuer are available through the Exchange, the Exchange may enroll the enrollee in a QHP issued by a different issuer, to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, as follows:

(i) As directed by the applicable State regulatory authority; or

(ii) If the applicable State regulatory authority declines to provide direction, in a similar QHP from a different issuer, as determined by the Exchange.

(4) The enrollee is determined upon annual redetermination eligible for cost-sharing reductions, in accordance with § 155.305(g), is currently enrolled in a bronze level QHP, and would be reenrolled in a bronze level QHP under paragraph (j)(1) or (2) of this section, then to the extent permitted by applicable State law, unless the enrollee terminates coverage, including termination of coverage in connection with voluntarily selecting a different QHP, in accordance with § 155.430, at the option of the Exchange, the Exchange may re-enroll such enrollee in a silver level QHP within the same product, with the same provider network, and with a lower or equivalent premium after the application of advance payments of the premium tax credit as the bronze level QHP into which the Exchange would otherwise re-enroll the enrollee under paragraph (j)(1) or (2) of this section.

(k) *Authorization of the release of tax data to support annual redetermination.* (1) The Exchange must have authorization from a qualified individual to obtain updated tax return information described in paragraph (b) of this section for purposes of conducting an annual redetermination.

(2) The Exchange is authorized to obtain the updated tax return information described in paragraph (b) of this section for a period of no more than five years based on a single authorization, provided that—

(i) An individual may decline to authorize the Exchange to obtain updated tax return information; or

(ii) An individual may authorize the Exchange to obtain updated tax return information for fewer than five years; and

(iii) The Exchange must allow an individual to discontinue, change, or renew his or her authorization at any time.

(l) *Limitation on redetermination.* To the extent that a qualified individual has requested an eligibility determination for insurance affordability programs in accordance with § 155.310(b) and the Exchange does not have an active authorization to obtain tax data as a part of the annual redetermination process, the Exchange must redetermine the qualified individual's eligibility only for enrollment in a QHP and notify the enrollee in accordance with the timing described in paragraph (d) of this section. The Exchange may not proceed with a redetermination for insurance affordability programs until such authorization has been obtained or the qualified individual continues his or her request for an eligibility determination for insurance affordability programs in accordance with § 155.310(b).

(m) *Special rule.* The Exchange must not redetermine a qualified individual's eligibility in accordance with this section if the qualified individual's eligibility was redetermined under this section during the prior year, and the qualified individual was not enrolled in a QHP through the Exchange at the time of such redetermination, and has not enrolled in a QHP through the Exchange since such redetermination.

§ 155.340 Administration of advance payments of the premium tax credit and cost-sharing reductions.

(a) *Requirement to provide information to enable advance payments of the premium tax credit and cost-sharing reductions.* In the event that the Exchange determines that a tax filer is eligible for advance payments of the premium tax credit, an

applicant is eligible for cost-sharing reductions, or that such eligibility for such programs has changed, the Exchange must, simultaneously—

(1) Transmit eligibility and enrollment information to HHS necessary to enable HHS to begin, end, or change advance payments of the premium tax credit or cost-sharing reductions; and

(2) Notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of advance payments of the premium tax credit or cost-sharing reductions, as applicable, including:

(i) The dollar amount of the advance payment; and

(ii) The cost-sharing reductions eligibility category.

(b) *Requirement to provide information related to employer responsibility.* (1) In the event that the Exchange determines that an individual is eligible for advance payments of the premium tax credit or cost-sharing reductions based in part on a finding that an individual's employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable, within the standard of 26 CFR 1.36B–2(c)(3)(v), or provide minimum essential coverage that does not meet the minimum value standard of § 156.145, the Exchange must transmit the individual's name and taxpayer identification number to HHS.

(2) If an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions notifies the Exchange that he or she has changed employers, the Exchange must transmit the enrollee's name and taxpayer identification number to HHS.

(3) In the event that an individual for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage from a QHP through the Exchange during a benefit year, the Exchange must—

(i) Transmit the individual's name and taxpayer identification number, and the effective date of coverage termination, to HHS, which will transmit it to the Secretary of the Treasury; and,

(ii) Transmit the individual's name and the effective date of the termination of coverage to his or her employer.

(c) *Requirement to provide information related to reconciliation of advance payments of the premium tax credit.* The Exchange must comply with the requirements of 26 CFR 1.36B–5 regarding reporting to the IRS and to taxpayers.

(d) *Timeliness standard.* The Exchange must transmit all information required in accordance with paragraphs (a) and (b) of this section promptly and without undue delay.

(e) *Allocation of advance payments of the premium tax credit among policies.* If one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan, then the advance payment must be allocated as follows:

(1) That portion of the advance payment of the premium tax credit that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR 1.36B–3(e), for the QHP policies properly allocated to EHB must be allocated among the QHP policies in a reasonable and consistent manner specified by the Exchange; and

(2) Any remaining advance payment of the premium tax credit must be allocated among the stand-alone dental policies in a reasonable and consistent manner specified by the Exchange.

(f) *Allocation of advance payments of the premium tax credit among policies offered through a Federally-facilitated Exchange.* If one or more advance payments of the premium tax credit are to be made on behalf of a tax filer (or two tax filers covered by the same plan(s)), and individuals in the tax filers' tax households are enrolled in more than one QHP or stand-alone dental plan offered through a Federally-facilitated Exchange, then that portion of the advance payment of the premium tax credit that is less than or equal to the aggregate adjusted monthly premiums, as defined in 26 CFR 1.36B–3(e),

properly allocated to EHB for the QHP policies, will be allocated among the QHP policies, as described in § 155.340(f)(1); and any remaining advance payment of the premium tax credit will be allocated among the stand-alone dental policies based on the methodology described in § 155.340(f)(2).

(1) That portion of the advance payment(s) of the premium tax credit to be allocated among QHP policies will be allocated based on the number of enrollees covered under the QHP, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR 147.102(e), with the portion allocated to any single QHP policy not to exceed the portion of the QHP's adjusted monthly premium properly allocated to EHB. If the portion of the advance payment(s) of the premium tax credit allocated to a QHP under this subparagraph exceeds the portion of the same QHP's adjusted monthly premium properly allocated to EHB, the remainder will be allocated evenly among all other QHPs in which individuals in the tax filers' tax households are enrolled.

(2) That portion of the advance payment(s) of the premium tax credit to be allocated among stand-alone dental policies will be allocated based on the number of enrollees covered under the stand-alone dental policy, weighted by the age of the enrollees, using the default uniform age rating curve established by the Secretary of HHS under 45 CFR 147.102(e), with the portion allocated to any single standalone dental policy not to exceed the portion of the stand-alone dental policy premium properly allocated to EHB. If the portion of the advance payment(s) of the premium tax credit allocated to a stand-alone dental policy under this subparagraph exceeds the portion of the same policy's premium properly allocated to EHB, the remainder will be allocated evenly among all other standalone dental policies in which individuals in the tax filers' tax households are enrolled.

(g) *Reduction of enrollee's portion of premium to account for advance payments of the premium tax credit.* If an Exchange is facilitating the collection and payment of premiums to QHP issuers and stand-alone dental plans on behalf of enrollees under § 155.240, and if a QHP issuer or stand-alone dental plan has been notified that it will receive an advance payment of the premium tax credit on behalf of an enrollee for whom the Exchange is facilitating such functions, the Exchange must—

(1) Reduce the portion of the premium for the policy collected from the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit; and

(2) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s) and the remaining premium owed for the policy.

(h) *Failure to reduce enrollee's premiums to account for advance payments of the premium tax credit.* If the Exchange discovers that it did not reduce an enrollee's premium by the amount of the advance payment of the premium tax credit, then the Exchange must notify the enrollee of the improper reduction within 45 calendar days of discovery of the improper reduction and refund the enrollee any excess premium paid by or for the enrollee as follows:

(1) Unless a refund is requested by or for the enrollee, the Exchange must, within 45 calendar days of discovery of the error, apply the excess premium paid by or for the enrollee to the enrollee's portion of the premium (or refund the amount directly). If any excess premium remains, the Exchange must then apply the excess premium to the enrollee's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess premium is fully refunded (or refund the remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, the Exchange must refund any excess premium within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(2) If a refund is requested by or for the enrollee, the refund must be provided within 45 calendar days of the date of the request.

(i) *Calculation of advance payments of the premium tax credit when policy coverage lasts less than the full coverage month.* (1) For plan years beginning with 2024 and beyond, when an Exchange determines that an individual is eligible for advance

payments of the premium tax credit and the enrollee is enrolled in a policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month—

(i) In an Exchange using the Federal eligibility and enrollment platform, the amount of the advance payment of the premium tax credit paid to the issuer of the policy must equal the product of—

(A) The advance payments of the premium tax credit applied to the policy for one month of coverage divided by the number of days in the month; and

(B) The number of days for which coverage is being provided in the month under the policy described in paragraph (i)(1)(i) of this section.

(ii) [Reserved]

(2) For plan years beginning with 2024 and beyond, a State Exchange operating its own platform will be required to calculate advance payments of the premium tax credit in accordance with a methodology that does not cause the amount of advance payments of the premium tax credit applied to an enrollee's monthly premium to exceed their expected monthly premium assistance credit amount when the enrollee is enrolled in a policy for less than the full coverage month, including when the enrollee is enrolled in multiple policies within a month, each lasting less than the full coverage month, and to prospectively report the methodology it intends to implement in the subsequent plan year to HHS under § 155.1200(b)(2).

§ 155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan.

(a) *Agreements.* The Exchange must enter into agreements with agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, as are necessary to fulfill the requirements of this subpart and provide copies of any such agreements to HHS upon request. Such agreements must include a clear delineation of the responsibilities of each agency to—

(1) Minimize burden on individuals;

(2) Ensure prompt determinations of eligibility and enrollment in the appropriate program without undue delay, based on the date the application is submitted to or redetermination is initiated by the Exchange or the agency administering Medicaid, CHIP, or the BHP;

(3) [Reserved]

(4) Ensure compliance with paragraphs (c), (d), (e), and (g) of this section.

(b) *Responsibilities related to individuals potentially eligible for Medicaid based on other information or through other coverage groups.* For an applicant who is not eligible for Medicaid based on the standards specified in § 155.305(c), the Exchange must assess the information provided by the applicant on his or her application to determine whether he or she is potentially eligible for Medicaid based on factors not otherwise considered in this subpart.

(c) *Individuals requesting additional screening.* The Exchange must notify an applicant of the opportunity to request a full determination of eligibility for Medicaid based on eligibility criteria that are not described in § 155.305(c), and provide such an opportunity. The Exchange must also make such notification to an enrollee and provide an enrollee such opportunity in any determination made in accordance with § 155.330 or § 155.335.

(d) *Notification of applicant and State Medicaid agency.* If an Exchange identifies an applicant as potentially eligible for Medicaid under paragraph (b) of this section or an applicant requests a full determination for Medicaid under paragraph (c) of this section, the Exchange must—

(1) Transmit all information provided on the application and any information obtained or verified by, the Exchange to the State Medicaid agency, promptly and without undue delay; and

(2) Notify the applicant of such transmittal.

(e) *Treatment of referrals to Medicaid on eligibility for advance payments of the premium tax credit and cost-sharing reductions.* The Exchange must consider an applicant who is described in paragraph (d) of this section and has not been determined eligible for

Medicaid based on the standards specified in § 155.305(c) as ineligible for Medicaid for purposes of eligibility for advance payments of the premium tax credit or cost-sharing reductions until the State Medicaid agency notifies the Exchange that the applicant is eligible for Medicaid.

(f) *Special rule.* If the Exchange verifies that a tax filer's household income, as defined in 26 CFR 1.36B–1(e), is less than 100 percent of the FPL for the benefit year for which coverage is requested, determines that the tax filer is not eligible for advance payments of the premium tax credit based on § 155.305(f)(2), and one or more applicants in the tax filer's household has been determined ineligible for Medicaid and CHIP based on income, the Exchange must—

(1) Provide the applicant with any information regarding income used in the Medicaid and CHIP eligibility determination; and

(2) Follow the procedures specified in § 155.320(c)(3).

(g) *Determination of eligibility for individuals submitting applications directly to an agency administering Medicaid, CHIP, or the BHP.* The Exchange, in consultation with the agency or agencies administering Medicaid, CHIP, and the BHP if a BHP is operating in the service area of the Exchange, must establish procedures to ensure that an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions is performed when an application is submitted directly to an agency administering Medicaid, CHIP, or the BHP if a BHP is operating in the service area of the Exchange. Under such procedures, the Exchange must—

(1) Accept, via secure electronic interface, all information provided on the application and any information obtained or verified by, the agency administering Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, for the individual, and not require submission of another application;

(2) Notify such agency of the receipt of the information described in paragraph (g)(1) of this section and final eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions.

(3) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this part.

(4) Not request information or documentation from the individual already provided to another agency administering an insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other agency.

(5) Determine the individual's eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, promptly and without undue delay, and in accordance with this subpart.

(6) Follow a streamlined process for eligibility determinations regardless of the agency that initially received an application.

(h) *Adherence to state decision regarding Medicaid and CHIP.* The Exchange and the Exchange appeals entity must adhere to the eligibility determination or appeals decision for Medicaid or CHIP made by the State Medicaid or CHIP agency, or the appeals entity for such agency.

(i) *Standards for sharing information between the Exchange and the agencies administering Medicaid, CHIP, and the BHP.* (1) The Exchange must utilize a secure electronic interface to exchange data with the agencies administering Medicaid, CHIP, and the BHP, if a BHP is operating in the service area of the Exchange, including to verify whether an applicant for insurance affordability programs has been determined eligible for Medicaid, CHIP, or the BHP, as specified in § 155.320(b)(1)(ii), and for other functions required under this subpart.

(2) *Model agreements.* The Exchange may utilize any model agreements as established by HHS for the purpose of sharing data as described in this section.

(j) *Transition from the Pre-existing Condition Insurance Plan (PCIP).* The Exchange must follow procedures established in accordance with 45 CFR 152.45 to transition PCIP enrollees to the Exchange to ensure that there are no lapses in health coverage.

§ 155.350 Special eligibility standards and process for Indians.

(a) *Eligibility for cost-sharing reductions.* (1) The Exchange must determine an applicant who is an Indian eligible for cost-sharing reductions if he or she—

(i) Meets the requirements specified in § 155.305(a) and § 155.305(f);

(ii) Is expected to have a household income, as defined in 26 CFR 1.36B–1(e) that does not exceed 300 percent of the FPL for the benefit year for which coverage is requested.

(2) The Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP through the Exchange.

(b) *Special cost-sharing rule for Indians regardless of income.* The Exchange must determine an applicant eligible for the special cost-sharing rule described in section 1402(d)(2) of the Affordable Care Act if he or she is an Indian, without requiring the applicant to request an eligibility determination for insurance affordability programs in accordance with § 155.310(b) in order to qualify for this rule.

(c) *Verification related to Indian status.* To the extent that an applicant attests that he or she is an Indian, the Exchange must verify such attestation by—

(1) Utilizing any relevant documentation verified in accordance with § 155.315(f);

(2) Relying on any electronic data sources that are available to the Exchange and which have been approved by HHS for this purpose, based on evidence showing that such data sources are sufficiently accurate and offer less administrative complexity than paper verification; or

(3) To the extent that approved data sources are unavailable, an individual is not represented in available data sources, or data sources are not reasonably compatible with an applicant's attestation, the Exchange must follow the procedures specified in § 155.315(f) and verify documentation provided by the applicant in accordance with the standards for acceptable documentation provided in section 1903(x)(3)(B)(v) of the Social Security Act.

§ 155.355 Right to appeal.

Individual appeals. The Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any eligibility determination notice issued to the applicant in accordance with § 155.310(g), § 155.330(e)(1)(ii), or § 155.335(h)(1)(ii).

SUBPART E—EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET: ENROLLMENT IN QUALIFIED HEALTH PLANS

§ 155.400 Enrollment of qualified individuals into QHPs.

(a) *General requirements.* The Exchange must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP in accordance with subpart D, and must—

(1) Notify the issuer of the applicant's selected QHP; and

(2) Transmit information necessary to enable the QHP issuer to enroll the applicant.

(b) *Timing of data exchange.* The Exchange must:

(1) Send eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay; and

(2) Establish a process by which a QHP issuer acknowledges the receipt of such information.

(3) Send updated eligibility and enrollment information to HHS promptly and without undue delay, in a manner and timeframe as specified by HHS.

(c) *Records.* The Exchange must maintain records of all enrollments in QHP issuers through the Exchange.

(d) *Reconcile files.* The Exchange must reconcile enrollment information with QHP issuers and HHS no less than on a monthly basis.

(e) *Premium payment.* Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, require effectuate an enrollment or to add coverage retroactively to an already effectuated enrollment. Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, establish a standard policy for setting premium payment deadlines:

(1) In a Federally-facilitated Exchange or State-Based Exchange on the Federal Platform:

(i) For prospective coverage to be effectuated under regular coverage effective dates, as provided for in § 155.410(f), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date, and no later than 30 calendar days from the coverage effective date.

(ii) For prospective coverage to be effectuated under special effective dates, as provided for in § 155.420(b)(2) and (3), the binder payment must consist of the first month's premium, and the deadline for making the binder payment must be no earlier than the coverage effective date and no later than 30 calendar days from the date the issuer receives the enrollment transaction or the coverage effective date, whichever is later.

(iii) For coverage to be effectuated under retroactive effective dates, as provided for in § 155.420(b)(2), including when retroactive effective dates are due to a delay until after special enrollment period verification, the binder payment must consist of the premium due for all months of retroactive coverage through the first prospective month of coverage, and the deadline for making the binder payment must be no earlier than 30 calendar days from the date the issuer receives the enrollment transaction. If only the premium for 1 month of coverage is paid, only prospective coverage should be effectuated, in accordance with § 155.420(b)(3).

(2) *Premium payment deadline extension.* Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, allow issuers experiencing billing or enrollment problems due to high volume or technical errors to implement a reasonable extension of the binder payment deadlines in paragraph (e)(1) of this section.

(f) *Processing enrollment transactions.* The Exchange may provide requirements to QHP issuers regarding the instructions for processing electronic enrollment-related transactions.

(g) *Premium payment threshold.* Exchanges may, and the Federally-facilitated Exchanges and State-Based Exchanges on the Federal Platform will, allow issuers to implement, a premium payment threshold policy under which issuers can consider enrollees to have paid all amounts due if the enrollees pay an amount sufficient to maintain a percentage of total premium paid out of the total premium owed equal to or greater than a level prescribed by the issuer, provided that the level is reasonable and that the level and the policy are applied in a uniform manner to all enrollees. If an applicant or enrollee satisfies the premium payment threshold policy, the issuer may:

(1) Effectuate an enrollment based on payment of the binder payment under paragraph (e) of this section.

(2) Avoid triggering a grace period for non-payment of premium, as described by § 156.270(d) of this subchapter or a grace period governed by State rules.

(3) Avoid terminating the enrollment for non-payment of premium as, described by §§ 156.270(g) of this subchapter and 155.430(b)(2)(ii)(A) and (B).

(h) *Requirements.* A State Exchange may rely on HHS to carry out the requirements of this section and other requirements contained within this subpart through a Federal platform agreement.

§ 155.405 Single streamlined application.

(a) *The application.* The Exchange must use a single streamlined application to determine eligibility and to collect information necessary for:

(1) Enrollment in a QHP;

(2) Advance payments of the premium tax credit;

(3) Cost-sharing reductions; and

(4) Medicaid, CHIP, or the BHP, where applicable.

(b) *Alternative application.* If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

(c) *Filing the single streamlined application.* The Exchange must—

(1) Accept the single streamlined application from an application filer;

(2) Provide the tools to file an application—

(i) Via an Internet Web site;

(ii) By telephone through a call center;

(iii) By mail; and

(iv) In person, with reasonable accommodations for those with disabilities, as defined by the Americans with Disabilities Act.

§ 155.410 Initial and annual open enrollment periods.

(a) *General requirements.* (1) The Exchange must provide an initial open enrollment period and annual open enrollment periods consistent with this section, during which qualified individuals may enroll in a QHP and enrollees may change QHPs.

(2) The Exchange may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period specified in paragraph (b) of this section, the annual open enrollment period specified in paragraph (e) of this section, or a special enrollment period described in § 155.420 of this subpart for which the qualified individual has been determined eligible.

(b) [*Omitted: not applicable after March 31, 2014*].

(c) [*Omitted: not applicable after March 31, 2014*].

(d) *Notice of annual open enrollment period.* Starting in 2014, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than the first day of the month before the open enrollment period begins and no later than the first day of the open enrollment period.

(e) *Annual open enrollment period.*

(1) [Omitted: not applicable to benefit years beginning after January 1, 2015.]

(2) For the benefit years beginning on January 1, 2016 and January 1, 2017, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year, and extends through January 31 of the benefit year.

(3) For the benefit years beginning on January 1, 2018 through January 1, 2021, the annual open enrollment period begins on November 1 and extends through December 15 of the calendar year preceding the benefit year.

(4) For the benefit years beginning on or after January 1, 2022—

(i) Subject to paragraph (e)(4)(ii) of this section, the annual open enrollment period begins on November 1 of the calendar year preceding the benefit year and extends through January 15 of the benefit year.

(ii) For State Exchanges not utilizing the Federal platform, for the benefit years beginning on or after January 1, 2022, an alternative annual open enrollment period end date may be adopted, provided the end date is no earlier than December 15 of the calendar year preceding the benefit year.

(f) *Effective date.* (1) [Omitted: not applicable after 2015 benefit year.]

(2) For the benefit years beginning on January 1, 2016 through January 1, 2021, the Exchange must ensure coverage is effective—

(i) January 1, for QHP selections received by the Exchange on or before December 15 of the calendar year preceding the benefit year.

(ii) February 1, for QHP selections received by the Exchange from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year.

(iii) March 1, for QHP selections received by the Exchange from January 16 through January 31 of the benefit year.

(3) For benefit years beginning on or after January 1, 2022, the Exchange must ensure that coverage is effective—

(i) Subject to paragraph (f)(3)(ii) of this section—

(A) January 1, for QHP selections received by the Exchange on or before December 15 of the calendar year preceding the benefit year.

(B) February 1, for QHP selections received by the Exchange from December 16 of the calendar year preceding the benefit year through January 15 of the benefit year.

(C) The first of the following month, for QHP selections received by the 15 of a month after January, if applicable under paragraph (e)(4)(ii) of this section.

(D) The first of the second following month, for plan selections received between the 16th and the end of a month, beginning January 16 of the benefit year, if applicable under paragraph (e)(4)(ii) of this section.

(ii) For State Exchanges not utilizing the Federal platform, for a QHP selection received by the Exchange during the open enrollment period for which effective dates specified in paragraph (f)(3)(i) of this section would apply, the Exchange may provide a coverage effective date that is earlier than specified in such paragraph.

(g) *Automatic enrollment.* The Exchange may automatically enroll qualified individuals, at such time and in such manner as HHS may specify, and subject to the Exchange demonstrating to HHS that it has good cause to perform such automatic enrollments.

§ 155.415 Allowing issuer or direct enrollment entity application assisters to assist with eligibility applications.

(a) *Exchange option.* An Exchange, to the extent permitted by State law, may permit issuer application assisters and direct enrollment entity application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and insurance affordability programs, provided that such issuer application assisters or direct enrollment entity application assisters meet the requirements set forth in paragraph (b) of this section.

(b) *Application assister requirements.* If permitted by an Exchange under paragraph (a) of this section, and to the extent permitted by State law, an issuer may permit its issuer application assisters and a direct enrollment entity may permit its direct enrollment entity application assisters to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, provided that such issuer or direct enrollment entity ensures that each of its issuer application assisters or direct enrollment entity application assisters at least—

(1) Receives training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations, and for application assisters providing assistance in the Federally-facilitated Exchanges or a State Exchange using the Federal platform, the assisters must fulfill this requirement by completing registration and training in a form and manner to be specified by HHS;

(2) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260; and

(3) Complies with applicable State law related to the sale, solicitation, and negotiation of health insurance products, including any State licensure laws applicable to the functions to be performed by the issuer application assister or direct enrollment entity application assister, as well as

State law related to confidentiality and conflicts of interest.

§ 155.420 Special enrollment periods.

(a) *General requirements.* (1) *General parameters*. The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(2) *Definition of dependent*. For the purpose of this section, "dependent," has the same meaning as it does in 26 CFR 54.9801–2, referring to any individual who is or who may become eligible for coverage under the terms of a QHP because of a relationship to a qualified individual or enrollee.

(3) *Use of special enrollment periods.* Except in the circumstances specified in paragraph (a)(4) of this section, the Exchange must allow a qualified individual or enrollee, and when specified in paragraph (d) of this section, his or her dependent to enroll in a QHP if one of the triggering events specified in paragraph (d) of this section occur.

(4) *Use of special enrollment periods by enrollees.* (i) If an enrollee has gained a dependent in accordance with paragraph (d)(2)(i) of this section, the Exchange must allow the enrollee to add the dependent to his or her current QHP, or, if the current QHP's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and his or her dependents to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or, at the option of the enrollee or dependent, enroll the dependent in any separate QHP.

(ii) (A) If an enrollee or their dependents become newly eligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or their dependents are not enrolled in a silver-level QHP, the Exchange must allow the enrollee and their dependents to change to a silver level QHP if they elect to change their QHP enrollment; or

(B) Beginning January 2022, if an enrollee or their dependents become newly ineligible for cost-sharing reductions in accordance with paragraph (d)(6)(i) or (ii) of this section and the enrollee or his or her dependents are enrolled in a silver-level QHP, the Exchange must allow the enrollee and their dependents to change to a QHP one metal level higher or lower if they elect to change their QHP enrollment;

(C) No later than January 1, 2024, if an enrollee or his or her dependents become newly ineligible for advance payments of the premium tax credit in accordance with paragraph (d)(6)(i) or (ii) of this section, the Exchange must allow the enrollee and his or her dependents to change to a QHP of any metal level, if they elect to change their QHP enrollment; or

(D) If an enrollee or his or her enrolled dependents qualify for a special enrollment period in accordance with paragraph (d)(16) of this section, the Exchange must allow the enrollee and his or her enrolled dependents to change to any available silver-level QHP if they elect to change their QHP enrollment. If a qualified individual or a dependent who is not an enrollee qualifies for a special enrollment period in accordance with paragraph (d)(16) of this section and has one or more household members who are enrollees, the Exchange must allow the enrollee to add the newly enrolling household member to his or her current QHP; or, to change to a silver-level QHP and add the newly enrolling household member to this silver-level QHP; or, to change to a silver level QHP and enroll the newly enrolling qualified individual or dependent in a separate QHP;

(iii) For the other triggering events specified in paragraph (d) of this section, except for paragraphs (d)(2)(i), (d)(4), and (d)(6)(i) and (ii) of this section for becoming newly eligible or ineligible for CSRs and paragraphs (d)(8), (9), (10), (12), (14), and (16) of this section:

(A) If an enrollee qualifies for a special enrollment period, the Exchange must allow the enrollee and his or her dependents, if applicable, to change to

another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter;

(B) If a dependent qualifies for a special enrollment period, and an enrollee who does not also qualify for a special enrollment period is adding the dependent to his or her QHP, the Exchange must allow the enrollee to add the dependent to his or her current QHP; or, if the QHP's business rules do not allow the dependent to enroll, the Exchange must allow the enrollee and his or her dependents to change to another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or enroll the new qualified individual in a separate QHP; or

(C) If a qualified individual who is not an enrollee qualifies for a special enrollment period and has one or more dependents who are enrollees who do not also qualify for a special enrollment period, the Exchange must allow the newly enrolling qualified individual to add himself or herself to a dependent's current QHP; or, if the QHP's business rules do not allow the qualified individual to enroll in the dependent's current QHP, to enroll with his or her dependent(s) in another QHP within the same level of coverage (or one metal level higher or lower, if no such QHP is available), as outlined in § 156.140(b) of this subchapter, or enroll himself or herself in a separate QHP.

(5) *Prior coverage requirement.* Qualified individuals who are required to demonstrate coverage in the 60 days prior to a qualifying event can either demonstrate that they had minimum essential coverage as described in 26 CFR 1.5000A–1(b) or demonstrate that they had coverage as described in paragraphs (d)(1)(iii) or (iv) of this section for 1 or more days during the 60 days preceding the date of the qualifying event; lived in a foreign country or in a United States territory for 1 or more days during the 60 days preceding the date of the qualifying event; are an Indian as defined by section 4 of the Indian Health Care Improvement Act; or lived for 1 or more days during the 60 days preceding the qualifying event or during their most recent preceding enrollment period, as specified in §§ 155.410 and 155.420, in a service area where no qualified health plan was available through the Exchange.

(b) *Effective dates.* (1) *Regular effective dates.* Except as specified in paragraphs (b)(2) and (3) of this section, for a QHP selection received by the Exchange from a qualified individual—

(i) Between the first and the fifteenth day of any month, the Exchange must ensure a coverage effective date of the first day of the following month; and

(ii) Between the sixteenth and the last day of any month, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) *Special effective dates.* (i) In the case of birth, adoption, placement for adoption, placement in foster care, or child support or other court order as described in paragraph (d)(2)(i) of this section, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, placement in foster care, or effective date of court order; or it may permit the qualified individual or enrollee to elect a coverage effective date of the first of the month following plan selection; or in accordance with paragraph (b)(1) of this section. If the Exchange permits the qualified individual or enrollee to elect a coverage effective date of either the first of the month following the date of plan selection or in accordance with paragraph (b)(1) of this section, the Exchange must ensure coverage is effective on the date duly selected by the qualified individual or enrollee.

(ii) In the case of marriage as described in paragraph (d)(2) of this section the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the first day of the month following plan selection.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment

period as described in paragraph (d)(4), (5), (9), (11), (12), or (13) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period.

(iv) If a qualified individual, enrollee, or dependent, as applicable, loses coverage as described in paragraph (d)(1) or (d)(6)(iii) of this section, or is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer contributions or government subsidies completely cease as described in paragraph (d)(15) of this section, gains access to a new QHP as described in paragraph (d)(7) of this section, becomes newly eligible for enrollment in a QHP through the Exchange in accordance with § 155.305(a)(2) as described in paragraph (d)(3) of this section, becomes newly eligible for advance payments of the premium tax credit in conjunction with a permanent move as described in paragraph (d)(6)(iv) of this section, and if the plan selection is made on or before the day of the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month following the date of the triggering event. If the plan selection is made after the date of the triggering event, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the following month, at the option of the Exchange.

Notwithstanding the requirements of this paragraph (b)(2)(iv) with respect to losses of coverage as described at paragraphs (d)(1), (d)(6)(iii), and (d)(15) of this section, at the option of the Exchange, if the plan selection is made on or before the last day of the month preceding the triggering event, the Exchange must ensure that the coverage effective date is the first day of the month in which the triggering event occurs.

(v) If an enrollee or his or her dependent dies as described in paragraph (d)(2)(ii) of this section, the Exchange must ensure that coverage is effective on the first day of the month following the plan selection, or it may permit the enrollee or his or her dependent to elect a coverage effective date in accordance with paragraph (b)(1) of this section. If the Exchange permits the enrollee or his or her dependent to elect a coverage effective date in accordance with paragraph (b)(1) of this section, the Exchange must ensure coverage is effective on the date duly selected by the enrollee or his or her dependent.

(vi) If a qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA or is newly provided a QSEHRA, each as described in paragraph (d)(14) of this section, and if the plan selection is made before the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following the date of the triggering event or, if the triggering event is on the first day of a month, on the date of the triggering event. If the plan selection is made on or after the day of the triggering event, the Exchange must ensure that coverage is effective on the first day of the month following plan selection.

(vii) If a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B– 1(e), is expected to be no greater than 150 percent of the Federal poverty level, enrolls in a QHP or changes from one QHP to another one time per month in accordance with paragraph (d)(16) of this section, the Exchange must ensure that coverage is effective in accordance with paragraph (b)(1) of this section or on the first day of the month following plan selection, at the option of the Exchange.

(3) *Option for earlier effective dates.* (i) For a QHP selection received by the Exchange under a special enrollment period for which regular effective dates specified in paragraph (b)(1) of this section would apply, the Exchange may provide a coverage effective date that is earlier than specified in such paragraph, and, beginning January 2022, a Federally-facilitated Exchange or a State Exchange on the Federal platform will

ensure that coverage is effective on the first day of the month following plan selection.

(ii) For a QHP selection received by the Exchange under a special enrollment period for which special effective dates specified in paragraph (b)(2)(ii) of this section would apply, the Exchange may provide a coverage effective date that is earlier than specified in such paragraph.

(4) *Advance payments of the premium tax credit and cost-sharing reductions.* Notwithstanding the standards of this section, the Exchange must ensure that advance payments of the premium tax credit and cost-sharing reductions adhere to the effective dates specified in § 155.330(f).

(5) *Option for earlier effective dates due to untimely notice of triggering event.* At the option of a qualified individual, enrollee or dependent who is eligible to select a plan during a period provided for under paragraph (c)(5) of this section, the Exchange must provide the earliest effective date that would have been available under paragraph (b) of this section, based on the applicable triggering event under paragraph (d) of this section.

(c) *Availability and length of special enrollment periods.* (1) *General rule.* Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(2) *Advanced availability.* A qualified individual or their dependent who is described in paragraph (d)(1), (d)(6)(iii), or (d)(15) of this section has 60 days before and, unless the Exchange exercises the option in paragraph (c)(6) of this section, 60 days after the triggering event to select a QHP. At the option of the Exchange, a qualified individual or their dependent who is described in paragraph (d)(7) of this section; who is described in paragraph (d)(6)(iv) of this section becomes newly eligible for advance payments of the premium tax credit as a result of a permanent move to a new State; or who is described in paragraph (d)(3) of this section and becomes newly eligible for enrollment in a QHP through the Exchange because they newly satisfy the requirements under § 155.305(a)(2), has 60 days before or after the triggering event to select a QHP.

(3) *Advanced availability for individuals with an individual coverage HRA or QSEHRA.* A qualified individual, enrollee, or his or her dependent who is described in paragraph (d)(14) of this section has 60 days before the triggering event to select a QHP, unless the HRA or QSEHRA was not required to provide the notice setting forth its terms to such individual or enrollee at least 90 days before the beginning of the plan year, as specified in 45 CFR 146.123(c)(6), 26 CFR 54.9802–4(c)(6), and 29 CFR 2590.702– 2(c)(6) or section 9831(d)(4) of the Internal Revenue Code, as applicable, in which case the qualified individual, enrollee, or his or her dependent has 60 days before or after the triggering event to select a QHP.

(4) *Special rule.* In the case of a qualified individual or enrollee who is eligible for a special enrollment period as described in paragraphs (d)(4), (5), or (9) of this section, the Exchange may define the length of the special enrollment period as appropriate based on the circumstances of the special enrollment period, but in no event may the length of the special enrollment period exceed 60 days.

(5) *Availability for individuals who did not receive timely notice of triggering events.* If a qualified individual, enrollee, or dependent did not receive timely notice of an event that triggers eligibility for a special enrollment period under this section, and otherwise was reasonably unaware that a triggering event described in paragraph (d) of this section occurred, the Exchange must allow the qualified individual, enrollee, or when applicable, his or her dependent to select a new plan within 60 days of the date that he or she knew, or reasonably should have known, of the occurrence of the triggering event.

(6) *Special rule for individuals losing Medicaid or CHIP.* Beginning January 1, 2024, or earlier, at the option of the Exchange, a qualified individual or their dependent(s) who is described in paragraph (d)(1)(i) of this section and whose loss of coverage is a loss of Medicaid or CHIP coverage shall have 90 days after the triggering event to select a QHP. If a State Medicaid or CHIP Agency allows or provides for a Medicaid

or CHIP reconsideration period greater than 90 days, the Exchange in that State may elect to provide a qualified individual or their dependent(s) who is described in paragraph (d)(1)(i) of this section and whose loss of coverage is a loss of Medicaid or CHIP coverage additional time to select a QHP, up to the number of days provided for the applicable Medicaid or CHIP reconsideration period.

(d) *Triggering events.* Subject to paragraphs (a)(3) through (5) of this section, as applicable, the Exchange must allow a qualified individual or enrollee, and, when specified below, his or her dependent, to enroll in or change from one QHP to another if one of the triggering events occur:

(1) The qualified individual or his or her dependent either:

(i) Loses minimum essential coverage. The date of the loss of coverage is the last day the consumer would have coverage under his or her previous plan or coverage;

(ii) Is enrolled in any non-calendar year group health plan, individual health insurance coverage, or qualified small employer health reimbursement arrangement (as defined in section 9831(d)(2) of the Internal Revenue Code); even if the qualified individual or his or her dependent has the option to renew or re-enroll in such coverage. The date of the loss of coverage is the last day of the plan year;

(iii) Loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) or loses access to health care services through coverage provided to a pregnant woman's unborn child, based on the definition of a child in 42 CFR 457.10. The date of the loss of coverage is the last day the qualified individual would have pregnancy-related coverage or access to health care services through the unborn child coverage; or

(iv) Loses medically needy coverage as described under section 1902(a)(10)(C) of the Social Security Act only once per calendar year. The date of the loss of coverage is the last day the consumer would have medically needy coverage.

(2)(i) The qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption, placement for adoption, or placement in foster care, or through a child support order or other court order.

(A) In the case of marriage, at least one spouse must demonstrate having minimum essential coverage as described in 26 CFR 1.5000A–1(b) for 1 or more days during the 60 days preceding the date of marriage.

(B) [Reserved]

(ii) At the option of the Exchange, the enrollee loses a dependent or is no longer considered a dependent through divorce or legal separation as defined by State law in the State in which the divorce or legal separation occurs, or if the enrollee, or his or her dependent, dies.

(3) The qualified individual, or his or her dependent, becomes newly eligible for enrollment in a QHP through the Exchange because he or she newly satisfies the requirements under § 155.305(a)(1) or (2);

(4) The qualified individual's or his or her dependent's, enrollment or nonenrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, misconduct, or inaction of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non- Exchange entity providing enrollment assistance or conducting enrollment activities. For purposes of this provision, misconduct includes the failure to comply with applicable standards under this part, part 156 of this subchapter, or other applicable Federal or State laws as determined by the Exchange.

(5) The enrollee or, his or her dependent adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) (i) The enrollee is determined newly eligible or newly ineligible for advance payments of the

premium tax credit or has a change in eligibility for cost-sharing reductions;

(ii) The enrollee's dependent enrolled in the same QHP is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions;

(iii) A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B–2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage;

(iv) A qualified individual who was previously ineligible for advance payments of the premium tax credit solely because of a household income below 100 percent of the FPL and who, during the same timeframe, was ineligible for Medicaid because he or she was living in a non-Medicaid expansion State, who either experiences a change in household income or moves to a different State resulting in the qualified individual becoming newly eligible for advance payments of the premium tax credit; or

(v) At the option of the Exchange, the qualified individual, or his or her dependent—

(A) Experiences a decrease in household income;

(B) Is newly determined eligible by the Exchange for advance payments of the premium tax credit; and

(C) Had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 days preceding the date of the financial change.

(7) The qualified individual or enrollee, or his or her dependent, gains access to new QHPs as a result of a permanent move and—

(i) Had minimum essential coverage as described in 26 CFR 1.5000A–1(b) for one or more days during the 60 days preceding the date of the permanent move.

(ii) [Reserved]

(8) The qualified individual—

(i) Who gains or maintains status as an Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; or

(ii) Who is or becomes a dependent of an Indian, as defined by section 4 of the Indian Health Care Improvement Act and is enrolled or is enrolling in a QHP through an Exchange on the same application as the Indian, may change from one QHP to another one time per month, at the same time as the Indian;

(9) The qualified individual or enrollee, or his or her dependent, demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide;

(10) A qualified individual or enrollee—

(i) Is a victim of domestic abuse or spousal abandonment as defined by 26 CFR 1.36B–2 or a dependent or unmarried victim within a household, is enrolled in minimum essential coverage, and sought to enroll in coverage separate from the perpetrator of the abuse or abandonment; or

(ii) Is a dependent of a victim of domestic abuse or spousal abandonment, on the same application as the victim, may enroll in coverage at the same time as the victim;

(11) A qualified individual or dependent—

(i) Applies for coverage on the Exchange during the annual open enrollment period or due to a qualifying event, is assessed by the

Exchange as potentially eligible for Medicaid or the Children's Health Insurance Program (CHIP), and is determined ineligible for Medicaid or CHIP by the State Medicaid or CHIP agency either after open enrollment has ended or more than 60 days after the qualifying event; or

(ii) Applies for coverage at the State Medicaid or CHIP agency during the annual open enrollment period, and is determined ineligible for Medicaid or CHIP after open enrollment has ended;

(12) The enrollment in a QHP through the Exchange was influenced by a material error related to plan benefits, service area, cost-sharing, or premium. A material error is one that is likely to have influenced a qualified individual's, enrollee's, or their dependent's enrollment in a QHP.

(13) At the option of the Exchange, the qualified individual provides satisfactory documentary evidence to verify his or her eligibility for an insurance affordability program or enrollment in a QHP through the Exchange following termination of Exchange enrollment due to a failure to verify such status within the time period specified in § 155.315 or is under 100 percent of the Federal poverty level and did not enroll in coverage while waiting for HHS to verify his or her citizenship, status as a national, or lawful presence; or

(14) The qualified individual, enrollee, or dependent newly gains access to an individual coverage HRA (as defined in 45 CFR 146.123(b)) or is newly provided a qualified small employer health reimbursement arrangement (QSEHRA) (as defined in section 9831(d)(2) of the Internal Revenue Code). The triggering event is the first day on which coverage for the qualified individual, enrollee, or dependent under the individual coverage HRA can take effect, or the first day on which coverage under the QSEHRA takes effect. An individual, enrollee, or dependent will qualify for this special enrollment period regardless of whether they were previously offered or enrolled in an individual coverage HRA or previously provided a QSEHRA, so long as the individual, enrollee, or dependent is not enrolled in the individual coverage HRA or covered by the QSEHRA on the day immediately prior to the triggering event.

(15) The qualified individual or his or her dependent is enrolled in COBRA continuation coverage for which an employer is paying all or part of the premiums, or for which a government entity is providing subsidies, and the employer completely ceases its contributions to the qualified individual's or dependent's COBRA continuation coverage or government subsidies completely cease. The triggering event is the last day of the period for which COBRA continuation coverage is paid for or subsidized, in whole or in part, by an employer or government entity. For purposes of this paragraph, "COBRA continuation coverage" has the meaning provided for in § 144.103 of this subchapter and includes coverage under a similar State program.

(16) At the option of the Exchange, a qualified individual or enrollee, or the dependent of a qualified individual or enrollee, who is eligible for advance payments of the premium tax credit, and whose household income, as defined in 26 CFR 1.36B–1(e), is expected to be no greater than 150 percent of the Federal poverty level, may enroll in a QHP or change from one QHP to another one time per month during periods of time when the applicable taxpayer's applicable percentage for purposes of calculating the premium assistance amount, as defined in section 36B(b)(3)(A) of the Internal Revenue Code, is set at zero.

(e) *Loss of coverage.* Loss of coverage described in paragraph (d)(1) of this section includes those circumstances described in 26 CFR 54.9801–6(a)(3)(i) through (iii) and in paragraphs (d)(1)(ii) through (iv) of this section. Loss of coverage does not include voluntary termination of coverage or other loss due to—

(1) Failure to pay premiums on a timely basis, including COBRA continuation coverage premiums prior to expiration of COBRA continuation coverage, except for circumstances in which an employer completely ceases its contributions to COBRA continuation coverage, or government subsidies of COBRA continuation coverage completely cease as described in paragraph (d)(15) of this section, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128.

(f) For purposes of this section, references to eligibility for advance payments of the premium tax credit refer to being eligible for such advance payments in an amount greater than zero dollars per month. References to ineligibility for advance payments of the premium tax credit refer to being ineligible for such payments or being eligible for such payments but being eligible for a maximum of zero dollars per month of such payments.

(g) *Pre-enrollment special enrollment period verification.* At the option of the Exchange, an Exchange may verify prior to processing a qualified individual's plan selection that the qualified individual is eligible for a special enrollment period under this section. In circumstances where the Exchange determines that such pre-enrollment special enrollment period verification may cause undue burden on qualified individuals, the Exchange may provide an exception to the pre-enrollment special enrollment period verification process, provided it does so in a manner consistent with the non-discrimination requirements under § 155.120(c). Exchanges on the Federal platform will conduct pre-enrollment special enrollment verification of eligibility only for special enrollment periods under paragraph (d)(1) of this section.

§ 155.430 Termination of Exchange enrollment or coverage.

(a) *General requirements.* The Exchange must determine the form and manner in which enrollment in a QHP through the Exchange may be terminated.

(b) *Termination events.* (1) *Enrollee-initiated terminations.* (i) The Exchange must permit an enrollee to terminate his or her coverage or enrollment in a QHP through the Exchange, including as a result of the enrollee obtaining other minimum essential coverage. To the extent the enrollee has the right to terminate the coverage under applicable State laws, including "free look" cancellation laws, the enrollee may do so, in accordance with such laws.

(ii) The Exchange must provide an opportunity at the time of plan selection for an enrollee to choose to remain enrolled in a QHP if he or she becomes eligible for other minimum essential coverage and the enrollee does not request termination in accordance with paragraph (b)(1)(i) of this section. If an enrollee does not choose to remain enrolled in a QHP in such situation, the Exchange must initiate termination of his or her enrollment in the QHP upon completion of the process specified in § 155.330(e)(2).

(iii) The Exchange must establish a process to permit individuals, including enrollees' authorized representatives, to report the death of an enrollee for purposes of initiating termination of the enrollee's Exchange enrollment. The Exchange may require the reporting party to submit documentation of the death. Any applicable premium refund, or premium due, must be processed by the deceased enrollee's QHP in accordance with State law.

(iv) The Exchange must permit an enrollee to retroactively terminate or cancel his or her coverage or enrollment in a QHP in the following circumstances:

(A) The enrollee demonstrates to the Exchange that he or she attempted to terminate his or her coverage or enrollment in a QHP and experienced a technical error that did not allow the enrollee to terminate his or her coverage or enrollment through the Exchange, and requests retroactive termination within 60 days after he or she discovered the technical error.

(B) The enrollee demonstrates to the Exchange that his or her enrollment in a QHP through the Exchange was unintentional, inadvertent, or erroneous and was the result of the error or misconduct of an officer, employee, or agent of the Exchange or HHS, its instrumentalities, or a non-Exchange entity providing enrollment assistance or conducting enrollment activities. Such enrollee must request cancellation within 60 days of discovering the unintentional, inadvertent, or erroneous enrollment. For purposes of this paragraph (b)(1)(iv)(B), misconduct includes the failure to comply with applicable standards under this part,

part 156 of this subchapter, or other applicable Federal or State requirements as determined by the Exchange.

(C) The enrollee demonstrates to the Exchange that he or she was enrolled in a QHP without his or her knowledge or consent by any third party, including third parties who have no connection with the Exchange, and requests cancellation within 60 days of discovering of the enrollment.

(2) *Exchange-initiated terminations.* The Exchange may initiate termination of an enrollee's enrollment in a QHP through the Exchange, and must permit a QHP issuer to terminate such coverage or enrollment, in the following circumstances:

(i) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(ii) Non-payment of premiums for coverage of the enrollee, and

(A) The exhaustion of the 3-month grace period, as described in § 156.270(d) and (g) of this subchapter, required for enrollees, who when first failing to timely pay premiums, are receiving advance payments of the premium tax credit. [*sic*— "; or,]

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The enrollee's coverage is rescinded in accordance with § 147.128 of this subchapter, after a QHP issuer demonstrates, to the reasonable satisfaction of the Exchange, if required by the Exchange, that the rescission is appropriate;

(iv) The QHP terminates or is decertified as described in § 155.1080; or

(v) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with § 155.410 or § 155.420.

(vi) The enrollee was enrolled in a QHP without his or her knowledge or consent by a third party, including by a third party with no connection with the Exchange.

(vii) Any other reason for termination of coverage described in § 147.106 of this subchapter.

(3) *Prohibition of issuer-initiated terminations due to aging-off.* Exchanges on the Federal platform must, and State Exchanges using their own platform may, prohibit QHP issuers from terminating dependent coverage of a child before the end of the plan year in which the child attains age 26 (or, if higher, the maximum age a QHP issuer is required to make available dependent coverage of children under applicable State law or the issuer's business rules), on the basis of the child's age, unless otherwise permitted.

(c) *Termination of coverage or enrollment tracking and approval.* The Exchange must—

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of enrollment in a QHP through the Exchange;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with § 155.400(b).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating enrollment of such individuals through the Exchange; and

(4) Retain records in order to facilitate audit functions.

(d) *Effective dates for termination of coverage or enrollment.* (1) For purposes of this section—

(i) Reasonable notice is defined as at least fourteen days before the requested effective date of termination; and

(ii) Changes in eligibility for advance payments of the premium tax credit and cost sharing reductions, including terminations, must adhere to the effective dates specified in § 155.330(f).

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of enrollment through the Exchange is—

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) If the enrollee does not provide reasonable notice, fourteen days after the termination is requested by the enrollee; or

(iii) At the option of the Exchange, on the date on which the termination is requested by the enrollee, or on another prospective date selected by the enrollee; or

(iv) If an Exchange does not require an earlier termination date in accordance with paragraph (d)(2)(iii) of this section, at the option of the QHP issuer, on a date on or after the termination is requested by the enrollee that is less than 14 days after the termination is requested by the enrollee, if the enrollee requests an earlier termination date; or

(v) At the option of the Exchange, for an individual who is newly determined eligible for Medicaid, CHIP, or the Basic Health Program, if a Basic Health Program is operating in the service area of the Exchange, the day before the enrollee's date of eligibility for Medicaid, CHIP, or the Basic Health Program.

(vi) The retroactive termination date requested by the enrollee, if specified by applicable State laws.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of enrollment in a QHP through the Exchange is the last day of eligibility, as described in § 155.330(f), unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of enrollment in a QHP through the Exchange will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of enrollment in a QHP through the Exchange should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments effectuated under § 155.420(b)(2)(iii).

(7) In the case of a termination due to death, the last day of enrollment in a QHP through the Exchange is the date of death.

(8) In cases of retroactive termination dates, the Exchange will ensure that appropriate actions are taken to make necessary adjustments to advance payments of the premium tax credit, cost-sharing reductions, premiums, claims, and user fees.

(9) In case of a retroactive termination in accordance with paragraph (b)(1)(iv)(A) of this section, the termination date will be no sooner than the date that would have applied under paragraph (d)(2) of this section, based on the date that the enrollee can demonstrate he or she contacted the Exchange to terminate his or her coverage or enrollment through the Exchange, had the technical error not occurred.

(10) In case of a retroactive cancellation or termination in accordance with paragraph (b)(1)(iv)(B) or (C) of this section, the cancellation date or termination date will be the original coverage effective date or a later date, as determined appropriate by the Exchange, based on the circumstances of the cancellation or termination.

(11) In the case of cancellation in accordance with paragraph (b)(2)(vi) of this section, the Exchange may cancel the enrollee's enrollment upon its determination that the enrollment was performed without the enrollee's knowledge or consent and following reasonable notice to the enrollee (where possible). The termination date will be the original coverage effective date.

(12) In the case of retroactive cancellations or terminations in accordance with paragraphs

(b)(1)(iv)(A), (B) and (C) of this section, such terminations or cancellations for the preceding coverage year must be initiated within a timeframe established by the Exchange based on a balance of operational needs and consumer protection. This timeframe will not apply to cases adjudicated through the appeals process.

(e) *Termination, cancellation, and reinstatement.* The Exchange may establish operational instructions as to the form, manner, and method for addressing each of the following:

(1) *Termination.* A termination is an action taken after a coverage effective date that ends an enrollee's enrollment through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was enrolled in coverage through the Exchange.

(2) *Cancellation.* A cancellation is specific type of termination action that ends a qualified individual's enrollment through the Exchange on the date such enrollment became effective resulting in enrollment through the Exchange never having been effective.

(3) *Reinstatement.* A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage.

SUBPART F—APPEALS OF ELIGIBILITY DETERMINATIONS FOR EXCHANGE PARTICIPATION AND INSURANCE AFFORDABILITY PROGRAMS (*Not included in this compilation.*)

SUBPART G—EXCHANGE FUNCTIONS IN THE INDIVIDUAL MARKET: ELIGIBILITY DETERMINATIONS FOR EXEMPTIONS.

§ 155.600 Definitions and general requirements.

(a) *Definitions.* For purposes of this subpart, the following terms have the following meaning:

Applicant means an individual who is seeking an exemption for him or herself through an application submitted to the Exchange.

Application filer means an applicant, an individual who is liable for the shared responsibility payment in accordance with section 5000A of the Code for an applicant, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

Exemption means an exemption from the shared responsibility payment.

Health care sharing ministry has the same meaning as it does in section 5000A(d)(2)(B)(ii) of the Code.

Indian tribe has the same meaning as it does in section 45A(c)(6) of the Code.

Required contribution has the same meaning as it does in section 5000A(e)(1)(B) of the Code.

Required contribution percentage means the product of eight percent and the rate of premium growth over the rate of income growth for the calendar year, rounded to the nearest one-hundredth of one percent.

Shared responsibility payment means the payment imposed with respect to a non-exempt individual who does not maintain minimum essential coverage in accordance with section 5000A(b) of the Code.

Tax filer has the same meaning as it does in § 155.300(a).

(b) *Attestation.* For the purposes of this subpart, any attestation that an applicant is to provide under this subpart may be made by the application filer on behalf of the applicant.

(c) *Reasonably compatible.* For purposes of this subpart, the Exchange must consider information through electronic data sources, other information provided by the applicant, or other information in the records of the Exchange to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not impact the eligibility of the applicant for the exemption or exemptions for which he or she applied.

(d) *Accessibility.* Information, including notices, forms, and applications, must be provided to

applicants in accordance with the standards specified in § 155.205(c).

(e) *Notices.* Any notice required to be sent by the Exchange to an individual in accordance with this subpart must be provided in accordance with the standards specified in § 155.230.

§ 155.605 Eligibility standards for exemptions.

(a) *Eligibility for an exemption through the Exchange.* Except as specified in paragraph (g) of this section, the Exchange must determine an applicant eligible for and issue a certificate of exemption for any month if the Exchange determines that he or she meets the requirements for one or more of the categories of exemptions described in this section for at least one day of the month.

(b) *Duration of single exemption.* Except as specified in paragraphs (c)(2) and (d) of this section, the Exchange may provide a certificate of exemption only for the calendar year in which an applicant submitted an application for such exemption.

(c) *Religious conscience.* (1) The Exchange must determine an applicant eligible for an exemption for any month if the applicant is a member of a recognized religious sect or division described in section 1402(g)(1) of the Code, and an adherent of established tenets or teachings of such sect or division, for such month in accordance with section 5000A(d)(2)(A) of the Code.

(2) *Duration of exemption for religious conscience.* (i) The Exchange must grant the certificate of exemption specified in this paragraph to an applicant who meets the standards provided in paragraph (c)(1) of this section for a month on a continuing basis, until the month after the month of the individual's 21st birthday, or until such time that an individual reports that he or she no longer meets the standards provided in paragraph (c)(1) of this section.

(ii) If the Exchange granted a certificate of exemption in this category to an applicant prior to his or her reaching the age of 21, the Exchange must send the applicant a notice upon reaching the age of 21 informing the applicant that he or she must submit a new exemption application to maintain the certificate of exemption.

(3) The Exchange must make an exemption in this category available prospectively or retrospectively.

(d) *Hardship*—(1) *General.* The Exchange must grant a hardship exemption to an applicant eligible for an exemption for at least the month before, the month or months during which, and the month after a specific event or circumstance, if the Exchange determines that:

(i) He or she experienced financial or domestic circumstances, including an unexpected natural or human-caused event, such that he or she had a significant, unexpected increase in essential expenses that prevented him or her from obtaining coverage under a qualified health plan;

(ii) The expense of purchasing a qualified health plan would have caused him or her to experience serious deprivation of food, shelter, clothing or other necessities; or

(iii) He or she has experienced other circumstances that prevented him or her from obtaining coverage under a qualified health plan.

(2) *Lack of affordable coverage based on projected income.* The Exchange must determine an applicant eligible for an exemption for a month or months during which he or she, or another individual the applicant attests will be included in the applicant's family, as defined in 26 CFR 1.36B–1(d), is unable to afford coverage in accordance with the standards specified in section 5000A(e)(1) of the Code, provided that—

(i) Eligibility for this exemption is based on projected annual household income;

(ii) An eligible employer-sponsored plan is only considered under paragraphs (d)(4)(iii) and (iv) of this section if it meets the minimum value standard described in § 156.145 of this subchapter.

(iii) For an individual who is eligible to purchase coverage under an eligible

employer-sponsored plan, the Exchange determines the required contribution for coverage such that—

(A) An individual who uses tobacco is treated as not earning any premium incentive related to participation in a wellness program designed to prevent or reduce tobacco use that is offered by an eligible employer-sponsored plan;

(B) Wellness incentives offered by an eligible employer-sponsored plan that do not relate to tobacco use are treated as not earned;

(C) In the case of an employee who is eligible to purchase coverage under an eligible employer-sponsored plan sponsored by the employee's employer, the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost self-only coverage.

(D) In the case of an individual who is eligible to purchase coverage under an eligible employer-sponsored plan as a member of the employee's family, as defined in 26 CFR 1.36B–1(d), the required contribution is the portion of the annual premium that the employee would pay (whether through salary reduction or otherwise) for the lowest cost family coverage that would cover the employee and all other individuals who are included in the employee's family who have not otherwise been granted an exemption through the Exchange.

(iv) For an individual who is ineligible to purchase coverage under an eligible employer-sponsored plan, the Exchange determines the required contribution for coverage in accordance with section 5000A(e)(1)(B)(ii) of the Code, inclusive of all members of the family, as defined in 26 CFR 1.36B–1(d), who have not otherwise been granted an exemption through the Exchange and who are not treated as eligible to purchase coverage under an eligible employer-sponsored plan, in accordance with paragraph (d)(4)(ii) of this section. If there is not a bronze level plan offered through the Exchange in the individual's county, the Exchange must use the annual premium for the lowest cost Exchange metal level plan, excluding catastrophic coverage, available in the individual market through the Exchange in the State in the county in which the individual resides to determine whether coverage exceeds the affordability threshold specified in section 5000A(e)(1) of the Code; and

(v) The applicant applies for this exemption prior to the last date on which he or she could enroll in a QHP through the Exchange for the month or months of a calendar year for which the exemption is requested.

(vi) The Exchange must make an exemption in this category available prospectively, and provide it for all remaining months in a coverage year, notwithstanding any change in an individual's circumstances.

(3) *Ineligible for Medicaid based on a State's decision not to expand.* The Exchange must determine an applicant eligible for an exemption for a calendar year if he or she would be determined ineligible for Medicaid for one or more months during the benefit year solely as a result of a State not implementing section 2001(a) of the Affordable Care Act.

(e) *Eligibility for an exemption through the IRS.* Hardship exemptions in this paragraph (e) can be claimed on a Federal income tax return without obtaining an exemption certificate number. The IRS may allow an individual to claim the hardship exemptions described in this paragraph (e) without requiring an exemption certificate number from the Exchange.

(1) *Filing threshold.* The IRS may allow an applicant to claim an exemption specified in HHS Guidance published September 18, 2014, entitled, "Shared Responsibility Guidance— Filing Threshold Hardship Exemption," and in IRS Notice 2014–76, section B (see *https://www.cms.gov/cciio/*).

(2) *Self-only coverage in an eligible employer-sponsored plan.* The IRS may allow an applicant to claim an exemption specified in HHS Guidance

published November 21, 2014, entitled, "Guidance on Hardship Exemptions for Persons Meeting Certain Criteria," and in IRS Notice 2014–76, section A (see *https://www.cms.gov/cciio/*).

(3) *Eligible for services through an Indian health care provider.* The IRS may allow an applicant to claim the exemption specified in HHS Guidance published September 18, 2014, entitled, "Shared Responsibility Guidance—Exemption for Individuals Eligible for Services through an Indian Health Care Provider," and in IRS Notice 2014–76, section E (see *https://www.cms.gov/cciio/*).

(4) *Ineligible for Medicaid based on a State's decision not to expand.* The IRS may allow an applicant to claim the exemption specified in HHS Guidance published November 21, 2014, entitled, "Guidance on Hardship Exemptions for Persons Meeting Certain Criteria," and in IRS Notice 2014–76, section F (see *https://www.cms.gov/cciio/*).

(5) *General hardship.* The IRS may allow an applicant to claim the exemption specified in HHS Guidance published September 12, 2018, entitled, ''Guidance on Claiming a Hardship Exemption through the Internal Revenue Service (IRS)'' (see *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Authority-to-Grant-HS-Exemptions-2018-Final-91218.pdf*) and in IRS Notice 2019–05 (see *https://www.irs.gov/pub/irs-drop/n-19-05.pdf*), for the 2018 tax year.

§ 155.610 Eligibility process for exemptions.

(a) *Application.* Except as specified in paragraphs (b) and (c) of this section, the Exchange must use an application established by HHS to collect information necessary for determining eligibility for and granting certificates of exemption as described in § 155.605.

(b) *Alternative application.* If the Exchange seeks to use an alternative application, such application, as approved by HHS, must request the minimum information necessary for the purposes identified in paragraph (a) of this section.

(c) *Exemptions through the eligibility process for coverage.* If an individual submits the application described in § 155.405 and then requests an exemption, the Exchange must use information collected for purposes of the eligibility determination for enrollment in a QHP and for insurance affordability programs in making the exemption eligibility determination, and must not request duplicate information or conduct repeat verifications to the extent that the Exchange finds that such information is still applicable, where the standards for such verifications adhere to the standards specified in this subpart.

(d) *Filing the exemption application.* The Exchange must—

(1) Accept the application from an application filer; and

(2) Provide the tools to file an application.

(3) [Omitted: not applicable after October 15, 2014.]

(e) *Collection of Social Security Numbers.* (1) The Exchange must require an applicant who has a Social Security number to provide such number to the Exchange.

(2) The Exchange may not require an individual who is not seeking an exemption for himself or herself to provide a Social Security number, except as specified in paragraph (e)(3) of this section.

(3) The Exchange must require an application filer to provide the Social Security number of a tax filer who is not an applicant only if an applicant attests that the tax filer has a Social Security number and filed a tax return for the year for which tax data would be utilized for verification of household income and family size for an exemption under § 155.605(g)(2) that requires such verification.

(f) *Determination of eligibility; granting of certificates.* The Exchange must determine an applicant's eligibility for an exemption in accordance with the standards specified in § 155.605, and grant a certificate of exemption to any applicant determined eligible.

(g) *Timeliness standards.* (1) The Exchange must determine eligibility for exemption promptly and without undue delay.

(2) The Exchange must assess the timeliness of eligibility determinations made under this subpart based on the period from the date of application to the date the Exchange notifies the applicant of its decision.

(h) *Exemptions for previous tax years.* (1) Except for the exemptions described in § 155.605(c) and (d), after December 31 of a given calendar year, the Exchange may decline to accept an application for an exemption that is available retrospectively for months for such calendar year, and must provide information to individuals regarding how to claim an exemption through the tax filing process.

(2) The Exchange will only accept an application for an exemption described in § 155.605(d)(1) during one of the 3 calendar years after the month or months during which the applicant attests that the hardship occurred.

(i) *Notification of eligibility determination for exemptions.* The Exchange must provide timely written notice to an applicant of any eligibility determination made in accordance with this subpart. In the case of a determination that an applicant is eligible for an exemption, this notification must include the exemption certificate number for the purposes of tax administration.

(j) *Retention of records for tax compliance.* (1) An Exchange must notify an individual to retain the records that demonstrate receipt of the certificate of exemption and qualification for the underlying exemption.

(2) In the case of any factor of eligibility that is verified through use of the special circumstances exception described in § 155.615(h), the records that demonstrate qualification for the underlying exemption are the information submitted to the Exchange regarding the circumstances that warranted the use of the exception, as well as records of the Exchange decision to allow such exception.

(k) *Incomplete application.* (1) If an applicant submits an application that does not include sufficient information for the Exchange to conduct a determination for eligibility of an exemption the Exchange must—

(i) Provide notice to the applicant indicating that information necessary to complete an eligibility determination is missing, specifying the missing information, and providing instructions on how to provide the missing information; and

(ii) Provide the applicant with a period of no less than 30 and no more than 90 days, in the reasonable discretion of the Exchange, from the date on which the notice described in paragraph (k)(1) of this section is sent to the applicant to provide the information needed to complete the application to the Exchange; and

(iii) Not proceed with the applicant's eligibility determination during the period described in paragraph (k)(2) of this section.

(2) If the Exchange does not receive the requested information within the time allotted in paragraph (k)(1)(ii) of this section, the Exchange must notify the applicant in writing that the Exchange cannot process the application and provide appeal rights to the applicant.

§ 155.615 Verification process related to eligibility for exemptions.

(a) *General rule.* Unless a request for modification is granted under paragraph (i) of this section, the Exchange must verify or obtain information as provided in this section in order to determine that an applicant is eligible for an exemption.

(b) *Verification related to exemption for religious conscience.* For any applicant who requests an exemption based on religious conscience, the Exchange must verify that he or she meets the standards specified in § 155.605(c) by—

(1) Except as specified in paragraph (b)(2) of this section, accepting a form that reflects that he or she is exempt from Social Security and Medicare taxes under section 1402(g)(1) of the Code;

(2) Except as specified in paragraphs (b)(3) and (4) of this section, accepting his or her attestation of membership in a religious sect or division, and verifying that the religious sect or division to

which the applicant attests membership is recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code.

(3) If information provided by an applicant regarding his or her membership in a religious sect or division is not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange must follow the procedures specified in paragraph (g) of this section.

(4) If an applicant attests to membership in a religious sect or division that is not recognized by the Social Security Administration as an approved religious sect or division under section 1402(g)(1) of the Code, the Exchange must provide the applicant with information regarding how his or her religious sect or division can pursue recognition under section 1402(g)(1) of the Code, and determine the applicant ineligible for this exemption until such time as the Exchange obtains information indicating that the religious sect or division has been approved.

(c) *Verification related to exemption for hardship*—(1) *In general.* For any applicant who requests an exemption based on hardship, except for the hardship exemptions described in § 155.605(d)(1)(i) and (iv), the Exchange must verify whether he or she has experienced the hardship to which he or she is attesting.

(2) *Lack of affordable coverage based on projected income.* (i) For any applicant who requests an exemption based on the hardship described in § 155.605(g)(2), the Exchange must verify the unavailability of affordable coverage through the procedures used to determine eligibility for advance payments of the premium tax credit, as specified in subpart D of this part, including the procedures described in § 155.315(c)(1), and the procedures used to verify eligibility for qualifying coverage in an eligible employer-sponsored plan, as specified in § 155.320(d), except as specified in § 155.615(f)(2)(ii).

(ii) The Exchange must accept an application filer's attestation for an applicant regarding eligibility for minimum essential coverage other than through an eligible employer-sponsored plan, instead of following the procedures specified in § 155.320(b).

(3) [Reserved]

(4) To the extent that the Exchange is unable to verify any of the information needed to determine an applicant's eligibility for an exemption based on hardship, the Exchange must follow the procedures specified in paragraph (g) of this section.

(d) *Inability to verify necessary information.* Except as otherwise specified in this subpart, for an applicant for whom the Exchange cannot verify information required to determine eligibility for an exemption, including but not limited to when electronic data is required in accordance with this subpart but data for individuals relevant to the eligibility determination for an exemption are not included in such data sources or when electronic data is required but it is not reasonably expected that data sources will be available within the time period as specified in § 155.315(f), the Exchange—

(1) Must make a reasonable effort to identify and address the causes of such inconsistency, including typographical or other clerical errors, by contacting the application filer to confirm the accuracy of the information submitted by the application filer;

(2) If unable to resolve the inconsistency through the process described in paragraph (g)(1) of this section, must—

(i) Provide notice to the applicant regarding the inconsistency; and

(ii) Provide the applicant with a period of 90 days from the date on which the notice described in paragraph (g)(2)(i) of this section is sent to the applicant to either present satisfactory documentary evidence via the channels available for the submission of an application, as described in § 155.610(d), except for by telephone, or otherwise to resolve the inconsistency.

(3) May extend the period described in paragraph (g)(2)(ii) of this section for an applicant if the applicant demonstrates that a good faith effort has

been made to obtain the required documentation during the period.

(4) During the period described in paragraph (g)(1) and (g)(2)(ii) of this section, must not grant a certificate of exemption based on the information subject to this paragraph.

(5) If, after the period described in paragraph (g)(2)(ii) of this section, the Exchange remains unable to verify the attestation, the Exchange must determine the applicant's eligibility for an exemption based on any information available from the data sources used in accordance with this subpart, if applicable, unless such applicant qualifies for the exception provided under paragraph (h) of this section, and notify the applicant of such determination in accordance with the notice requirements specified in § 155.610(i), including notice that the Exchange is unable to verify the attestation.

(e) *Exception for special circumstances.* For an applicant who does not have documentation with which to resolve the inconsistency through the process described in paragraph (g)(2) of this section because such documentation does not exist or is not reasonably available and for whom the Exchange is unable to otherwise resolve the inconsistency, the Exchange must provide an exception, on a case-by-case basis, to accept an applicant's attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.

(f) *Flexibility in information collection and verification.* HHS may approve an Exchange Blueprint in accordance with § 155.105(d) or a significant change to the Exchange Blueprint in accordance with § 155.105(e) to modify the methods to be used for collection of information and verification as set forth in this subpart, as well as the specific information required to be collected, provided that HHS finds that such modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, and that applicable requirements under §§ 155.260, 155.270, and paragraph (j) of this section, and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of such information will be met.

(g) *Applicant information.* The Exchange may not require an applicant to provide information beyond the minimum necessary to support the eligibility process for exemptions as described in this subpart.

(h) *Validation of Social Security number.* (1) For any individual who provides his or her Social Security number to the Exchange, the Exchange must transmit the Social Security number and other identifying information to HHS, which will submit it to the Social Security Administration.

(2) To the extent that the Exchange is unable to validate an individual's Social Security number through the Social Security Administration, or the Social Security Administration indicates that the individual is deceased, the Exchange must follow the procedures specified in paragraph (g) of this section, except that the Exchange must provide the individual with a period of 90 days from the date on which the notice described in paragraph (g)(2)(i) of this section is received for the applicant to provide satisfactory documentary evidence or resolve the inconsistency with the Social Security Administration. The date on which the notice is received means 5 days after the date on the notice, unless the individual demonstrates that he or she did not receive the notice within the 5 day period.

§ 155.620 Eligibility redeterminations for exemptions during a calendar year.

(a) *General requirement.* The Exchange must redetermine the eligibility of an individual with an exemption granted by the Exchange if it receives and verifies new information reported by such an individual, except for the exemption described in § 155.605(g)(2).

(b) *Requirement for individuals to report changes.* (1) Except as specified in paragraph (b)(2) of this section, the Exchange must require an individual who has a certificate of exemption from the Exchange to report any change with respect to the eligibility standards for the exemption as specified in § 155.605, except for the exemption described in § 155.605(g)(2), within 30 days of such change.

(2) The Exchange must allow an individual with a certificate of exemption to report changes via the channels available for the submission of an application, as described in§ 155.610(d).

(c) *Verification of reported changes.* The Exchange must—

(1) Verify any information reported by an individual with a certificate of exemption in accordance with the processes specified in § 155.615 prior to using such information in an eligibility redetermination.

(2) Notify an individual in accordance with § 155.610(i) after redetermining his or her eligibility based on a reported change.

(3) Provide periodic electronic notifications regarding the requirements for reporting changes and an individual's opportunity to report any changes, to an individual who has a certificate of exemption for which changes must be reported in accordance with § 155.620(b) and who has elected to receive electronic notifications, unless he or she has declined to receive such notifications.

(d) *Effective date of changes.* The Exchange must implement a change resulting from a redetermination under this section for the month or months after the month in which the redetermination occurs, such that a certificate that was provided for the month in which the redetermination occurs, and for prior months remains effective.

§ 155.625 Options for conducting eligibility determinations for exemptions.

(a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—

(1) Directly or through contracting arrangements in accordance with § 155.110(a); or

(2) By use of the HHS service under paragraph (b) of this section.

(b) *Use of HHS service.* Notwithstanding the requirements of this subpart, the Exchange may adopt an exemption eligibility determination made by HHS.

(c) *Administration of hardship exemption based on affordability.* States may choose to administer the hardship exemption under § 155.605(d)(2) only and delegate to HHS all other exemption determinations generally administered by HHS.

§ 155.630 Reporting.

Requirement to provide information related to tax administration. If the Exchange grants an individual a certificate of exemption in accordance with § 155.610(i), the Exchange must transmit to the IRS at such time and in such manner as the IRS may specify—

(a) The individual's name, Social Security number, and exemption certificate number;

(b) Any other information required in guidance published by the Secretary of the Treasury in accordance with 26 CFR 601.601(d)(2).

§ 155.635 Right to appeal.

(a) [Omitted: not applicable after October 15, 2014.]

(b) For an application submitted on or after October 15, 2014, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any notification issued in accordance with § 155.610(i) and § 155.625(b)(2)(i).

SUBPART H—EXCHANGE FUNCTIONS: SMALL BUSINESS HEALTH OPTIONS PROGRAM (SHOP)

§ 155.700 Standards for the establishment of a SHOP.

(a) *General requirement.* (1) For plan years beginning before January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(2) For plan years beginning on or after January 1, 2018, an Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers in facilitating the enrollment of their employees in qualified health plans.

(b) *Definition.* For the purposes of this subpart:

Group participation rate means the minimum percentage of all eligible individuals or employees of an employer that must be enrolled.

SHOP application filer means an applicant, an authorized representative, an agent or broker of the employer, or an employer filing for its employees where not prohibited by other law.

§ 155.705 Functions of a SHOP for plan years beginning prior to January 1, 2018.

(a) *Exchange functions that apply to SHOP*. The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP for plan years beginning on or after January 1, 2015, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer, unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section.

(3) The requirement to issue certificates of exemption in accordance with § 155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) *Unique functions of a SHOP*. The SHOP must also provide the following unique functions:

(1) *Enrollment and eligibility functions*. The SHOP must adhere to the requirements outlined in Subpart H.

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP for plan years beginning on or after January 1, 2015, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) *SHOP options with respect to employer choice requirements.* (i) [Omitted: not applicable to plan years beginning on or after January 1, 2015.]

(ii) Unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section, for plan years beginning on or after January 1, 2015, a SHOP:

(A) Must allow an employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, and

(B) May allow an employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(iii) [Omitted: not applicable to plan years beginning on or after January 1, 2015.]

(iv) Unless the Secretary makes an election pursuant to paragraph (b)(3)(vi) of this section, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section, or

(B) The employer may choose a single QHP.

(v) For plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make stand-alone dental plans available to qualified employees and their dependents:

(A) The employer may choose to make available a single stand-alone dental plan.

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in § 156.150(b)(2) of this subchapter.

(vi) – (vii) [Omitted: not applicable to plan years beginning on or after January 1, 2016.]

(viii) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make QHPs available to qualified employees and their dependents described in paragraphs (b)(3)(viii)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make QHPs available to qualified employees and their dependents as described in paragraph (b)(3)(viii)(C) of this section.

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section;

(B) The employer may choose a single QHP; or

(C) The employer may offer its qualified employees a choice of all QHPs offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in section 1302(d)(1) of the Affordable Care Act and implemented in § 156.140(b) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(ix) For plan years beginning on or after January 1, 2017, a Federally-facilitated SHOP will provide a qualified employer a choice of at least the two methods to make stand-alone dental plans available to qualified employees and their dependents described in paragraphs (b)(3)(ix)(A) and (B) of this section, and may also provide a qualified employer with a choice of a third method to make standalone dental plans available to qualified employees and their dependents as described in paragraph (b)(3)(ix)(C) of this section.

(A) The employer may choose to make available a single stand-alone dental plan;

(B) The employer may choose to make available all stand-alone dental plans offered through a Federally-facilitated SHOP at a level of coverage as described in § 156.150(b)(2) of this subchapter; or

(C) The employer may offer its qualified employees a choice of all stand-alone dental plans offered through a Federally-facilitated SHOP by a single issuer across all available levels of coverage, as described in § 156.150(b)(2) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(x) States operating a State-based Exchange utilizing the Federal platform for SHOP enrollment functions will have the same employer choice models available as States with a Federally-facilitated SHOP, except that a State with a State-based Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering the employer choice models specified in paragraphs (b)(3)(viii)(C) and (b)(3)(ix)(C) of this section in that State, provided that the State notifies HHS of that decision in advance of the annual QHP certification application deadline, by a date to be established by HHS.

(4)(i) *Premium aggregation.* Consistent with the effective dates set forth in paragraph (b)(4)(ii) of this section, the SHOP must perform the following functions related to premium payment administration:

(A) Provide each qualified employer with a bill on a monthly basis that identifies the employer contribution, the employee contribution, and the total amount that is due to the QHP issuers from the qualified employer;

(B) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees except as provided for in paragraph (b)(4)(ii)(A) of this section; and

(C) Maintain books, records, documents, and other evidence of accounting procedures and practices of the premium aggregation program for each benefit year for at least 10 years.

(ii) The SHOP may establish one or more standard processes for premium calculation, premium payment, and premium collection.

(A) The SHOP may, upon an election by a qualified employer, enter into an agreement with a qualified employer to facilitate the administration of continuation coverage by collecting premiums for continuation coverage enrolled in through the SHOP directly from a person enrolled in continuation coverage through the SHOP consistent with applicable law and the terms of the group health plan, and remitting premium payments for this coverage to QHP issuers. A Federally-facilitated SHOP may elect to limit this service to the collection of premiums related to continuation coverage required under 29 U.S.C. 1161, *et seq.*

(B) Qualified employers in a Federally-facilitated SHOP must make premium payments according to a timeline and process established by HHS:

(*1*) In a Federally-facilitated SHOP, payment for the group's first month of coverage must be received by the premium aggregation services vendor on or before the 20th day of the month prior to the month that coverage begins.

(*2*) In a Federally-facilitated SHOP, when coverage is effectuated retroactively, payment for the first month's coverage and all months of the retroactive coverage must be received and processed no later than 30 days after the event that triggers the eligibility for retroactive coverage. If payment is received on or before the 20th day of a month, coverage will be effectuated upon the first day of the following month retroactive to the effective date of coverage. If payment is received after the 20th day of a month, coverage will be effectuated upon the first day of the second following month retroactive to the effective date of coverage, provided that the payment includes the premium for the intervening month.

(C) For a Federally-facilitated SHOP, the premium for coverage lasting less than 1 month must equal the product of:

(*1*) The premium for 1 month of coverage divided by the number of days in the month; and

(*2*) The number of days for which coverage is being provided in the month described in paragraph (b)(4)(ii)(C)(*1*) of this section.

(iii) *Effective dates.* (A) A State-based SHOP may elect to perform these functions for plan years beginning before January 1, 2015, but need not do so.

(B) A Federally-facilitated SHOP will perform these functions only in plan years beginning on or after January 1, 2015.

(5) *QHP Certification.* With respect to certification of QHPs in the small group market,

the SHOP must ensure each QHP meets the requirements specified in § 156.285 of this subchapter.

(6) *Rates and rate changes.* The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is no more frequently than quarterly.

(A) In a Federally-facilitated SHOP, rates may be updated quarterly with effective dates of January 1, April 1, July 1, or October 1 of each calendar year, beginning with rates effective no sooner than July 1, 2014. The updated rates must be submitted to HHS at least 60 days in advance of the effective date of the rates.

(B) [Reserved]

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) *QHP availability in merged markets.* If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit a qualified employee to enroll in any QHP meeting level of coverage requirements described in section 1302(d) of the Affordable Care Act.

(8) *QHP availability in unmerged markets.* If a State does not merge the individual and small group market risk pools, the SHOP must permit each qualified employee to enroll only in QHPs in the small group market.

(9) *SHOP expansion to large group market.* If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) *Participation rules.* Subject to § 147.104 of this subchapter, the SHOP participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) For plan years beginning before January 1, 2016, subject to § 147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of qualified employees accepting coverage under the employer's group health plan, divided by the number of qualified employees offered coverage, excluding from the calculation any employee who, at the time the employer submits the SHOP application, is enrolled in coverage through another employer's group health plan or through a governmental plan such as Medicare, Medicaid, or TRICARE. For purposes of this calculation, qualified employees who are former employees will not be counted.

(ii) For plan years beginning on or after January 1, 2016, subject to § 147.104 of this subchapter, a Federally-facilitated SHOP must use a minimum participation rate of 70 percent, calculated as the number of full-time employees accepting coverage offered by a qualified employer plus the number of full-time employees who, at the time the employer submits the SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of fulltime employees offered coverage.

(iii) Notwithstanding paragraphs (b)(10)(i) and (ii) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) *Premium calculator*. In the SHOP, the premium calculator described in § 155.205(b)(6) must facilitate the comparison of available QHPs after the application of any applicable employer contribution in lieu of any advance payment of the premium tax credit and any cost sharing reductions.

(i) To determine the employer and employee contributions, a SHOP may establish one or more standard methods that employers may use to define their contributions toward employee and dependent coverage.

(ii) A Federally-facilitated SHOP must use the following method for employer contributions:

(A) When the employer offers a single plan to qualified employees, the employer must use a fixed contribution methodology under which the employer contributes a fixed percentage of the plan's premium for each qualified employee and, if applicable, for each dependent of a qualified employee. The employer's contribution is calculated based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(B) When the employer offers a choice of plans to qualified employees, the employer may use a fixed contribution methodology or a reference plan contribution methodology. Under the fixed contribution methodology, the employer contributes a fixed percentage of the premiums for each qualified employee and, if applicable, for each dependent of a qualified employee, across all plans in which any qualified employee, and, if applicable, any dependent of a qualified employee, is enrolled. Under the reference plan contribution methodology, the employer will select a plan from among the plans offered by the employer as described in paragraphs (b)(2) and (3) of this section to serve as a reference plan on which contributions will be based, and then will define a percentage contribution toward premiums under the reference plan; the resulting contribution amounts under the reference plan will be applied toward any plan in which a qualified employee or, if applicable, any dependent of a qualified employee, is enrolled, up to the lesser of the contribution amount or the total amount of any premium for the selected plan before application of a tobacco surcharge, if applicable. The employer's contribution is calculated based on an enrollee's premium before any applicable tobacco surcharge, based on the total premium owed for the enrollee, is applied.

(C) The employer will define a percentage contribution toward premiums for employee-only coverage and, if dependent coverage is offered, a percentage contribution toward premiums for dependent coverage. To the extent permitted by other applicable law, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP may permit an employer to define a different percentage contribution for full-time employees from the percentage contribution it defines for non-full-time employees, and it may permit an employer to define a different percentage contribution for dependent coverage for full-time employees from the percentage contribution it defines for dependent coverage for non-full-time employees.

(D) A Federally-facilitated SHOP may permit employers to base contributions on a calculated composite premium for employees, for adult dependents, and for dependents below age 21.

(c) *Coordination with individual market Exchange for eligibility determinations.* A SHOP must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to § 155.100(a)(2).

(d) *Duties of Navigators in the SHOP*. In States that have elected to operate only a SHOP pursuant to § 155.100(a)(2), at State option and if State law permits the Navigator duties described in § 155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

(e) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.706 is applicable for plan years beginning on or after January 1, 2018.

§ 155.706 Functions of a SHOP for plan years beginning on or after January 1, 2018.

(a) *Exchange functions that apply to SHOP.* The SHOP must carry out all the required functions of an Exchange described in this subpart and in subparts C, E, K, and M of this part, except:

(1) Requirements related to individual eligibility determinations in subpart D of this part;

(2) Requirements related to enrollment of qualified individuals described in subpart E of this part;

(3) The requirement to issue certificates of exemption in accordance with § 155.200(b); and

(4) Requirements related to the payment of premiums by individuals, Indian tribes, tribal organizations and urban Indian organizations under § 155.240.

(b) *Unique functions of a SHOP.* The SHOP must also provide the following unique functions:

(1) *Enrollment and eligibility functions.* The SHOP must adhere to the requirements outlined in subpart H.

(2) *Employer choice requirements.* The SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer.

(3) *SHOP options with respect to employer choice requirements.* (i) A SHOP:

(A) Must allow an employer to make available to qualified employees all QHPs at the level of coverage selected by the employer as described in paragraph (b)(2) of this section, and

(B) May allow an employer to make one or more QHPs available to qualified employees by a method other than the method described in paragraph (b)(2) of this section.

(ii) A Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

(A) The employer may choose a level of coverage as described in paragraph (b)(2) of this section, or

(B) The employer may choose a single QHP.

(iii) A SHOP may, and a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make stand-alone dental plans available to qualified employees:

(A) The employer may choose to make available a single stand-alone dental plan.

(B) The employer may choose to make available all stand-alone dental plans offered through a SHOP.

(iv) A SHOP may also provide a qualified employer with a choice of a third method to make QHPs available to qualified employees by offering its qualified employees a choice of all QHPs offered through the SHOP by a single issuer across all available levels of coverage, as described in section 1302(d)(1) of the Affordable Care Act and implemented in § 156.140(b) of this subchapter. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(v) A SHOP may also provide a qualified employer with a choice of a third method to make stand-alone dental plans available to qualified employees by offering its qualified

employees a choice of all stand-alone dental plans offered through the SHOP by a single issuer. A State with a Federally-facilitated SHOP may recommend that the Federally-facilitated SHOP not make this additional option available in that State, by submitting a letter to HHS in advance of the annual QHP certification application deadline, by a date to be established by HHS. The State's letter must describe and justify the State's recommendation, based on the anticipated impact this additional option would have on the small group market and consumers.

(vi) States operating a State Exchange utilizing the Federal platform for SHOP enrollment functions will have the same employer choice models available as States with a Federally-facilitated SHOP, except that a State with a State Exchange utilizing the Federal platform for SHOP enrollment functions may decide against offering the employer choice models specified in paragraphs (b)(3)(iv) and (v) of this section in that State, provided that the State notifies HHS of that decision in advance of the annual QHP certification application deadline, by a date to be established by HHS.

(4) *Continuation of Coverage.* The SHOP may, upon an election by a qualified employer, enter into an agreement with a qualified employer to facilitate the administration of continuation coverage by collecting premiums for continuation coverage enrolled in through the SHOP directly from a person enrolled in continuation coverage through the SHOP consistent with applicable law and the terms of the group health plan, and remitting premium payments for this coverage to QHP issuers.

(5) *QHP Certification.* With respect to certification of QHPs in the small group market, the SHOP must ensure each QHP meets the requirements specified in § 156.285 of this subchapter.

(6) *Rates and rate changes.* The SHOP must—

(i) Require all QHP issuers to make any change to rates at a uniform time that is no more frequently than quarterly.

(A) In a Federally-facilitated SHOP, rates may be updated quarterly with effective dates of January 1, April 1, July 1, or October 1 of each calendar year. The updated rates must be submitted to HHS at least 60 days in advance of the effective date of the rates.

(B) [Reserved]

(ii) Prohibit all QHP issuers from varying rates for a qualified employer during the employer's plan year.

(7) *QHP availability in merged markets.* If a State merges the individual market and the small group market risk pools in accordance with section 1312(c)(3) of the Affordable Care Act, the SHOP may permit employer groups to enroll in any QHP meeting level of coverage requirements described in section 1302(d) of the Affordable Care Act.

(8) *QHP availability in unmerged markets.* If a State does not merge the individual and small group market risk pools, the SHOP must permit employer groups to enroll only in QHPs in the small group market.

(9) *SHOP expansion to large group market.* If a State elects to expand the SHOP to the large group market, a SHOP must allow issuers of health insurance coverage in the large group market in the State to offer QHPs in such market through a SHOP beginning in 2017 provided that a large employer meets the qualified employer requirements other than that it be a small employer.

(10) *Participation rules.* Subject to § 147.104 of this subchapter, the SHOP may authorize a uniform group participation rate for the offering of health insurance coverage in the SHOP, which must be a single, uniform rate that applies to all groups and issuers in the SHOP. If the SHOP authorizes a minimum participation rate, such rate must be based on the rate of employee participation in the SHOP, not on the rate of employee participation in any particular QHP or QHPs of any particular issuer.

(i) Subject to § 147.104 of this subchapter, a Federally-facilitated SHOP must use a

minimum participation rate of 70 percent, calculated as the number of full-time employees accepting coverage offered by a qualified employer plus the number of full-time employees who, at the time the employer submits the SHOP group enrollment, are enrolled in coverage through another group health plan, governmental coverage (such as Medicare, Medicaid, or TRICARE), coverage sold through the individual market, or in other minimum essential coverage, divided by the number of fulltime employees offered coverage.

(ii) Notwithstanding paragraphs (b)(10)(i) of this section, a Federally-facilitated SHOP may utilize a different minimum participation rate in a State if there is evidence that a State law sets a minimum participation rate or that a higher or lower minimum participation rate is customarily used by the majority of QHP issuers in that State for products in the State's small group market outside the SHOP.

(11) *Premium calculator.* In the SHOP, the premium calculator described in § 155.205(b)(6) must facilitate the comparison of available QHPs.

(c) *Coordination with individual market Exchange for eligibility determinations.* A SHOP that collects employee eligibility or enrollment data must provide data related to eligibility and enrollment of a qualified employee to the individual market Exchange that corresponds to the service area of the SHOP, unless the SHOP is operated pursuant to § 155.100(a)(2).

(d) *Duties of Navigators in the SHOP.* In States that have elected to operate only a SHOP pursuant to § 155.100(a)(2), at State option and if State law permits the Navigator duties described in § 155.210(e)(3) and (4) may be fulfilled through referrals to agents and brokers.

(e) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 155.710 Eligibility standards for SHOP.

(a) *General requirement.* The SHOP must permit qualified employers to purchase coverage for qualified employees through the SHOP.

(b) *Employer eligibility requirements.* An employer is a qualified employer eligible to purchase coverage through a SHOP if such employer—

(1) Is a small employer;

(2) Elects to offer, at a minimum, all full-time employees coverage in a QHP through a SHOP; and

(3) Either—

(i) Has its principal business address in the Exchange service area and offers coverage to all its full-time employees through that SHOP; or

(ii) Offers coverage to each eligible employee through the SHOP serving that employee's primary worksite.

(c) *Participating in multiple SHOPs.* If an employer meets the criteria in paragraph (b) of this section and makes the election described in (b)(3)(ii) of this section, a SHOP shall allow the employer to offer coverage to those employees whose primary worksite is in the SHOP's service area.

(d) *Continuing eligibility.* The SHOP must treat a qualified employer which ceases to be a small employer solely by reason of an increase in the number of employees of such employer as a qualified employer until the qualified employer otherwise fails to meet the eligibility criteria of this section or elects to no longer purchase coverage for qualified employees through the SHOP.

(e) *Employee eligibility requirements.* An employee is a qualified employee eligible to enroll in coverage through a SHOP if such employee receives an offer of coverage from a qualified employer. A qualified employee is eligible to enroll his or her dependents in coverage through a SHOP if the offer from the qualified employer includes an offer of dependent coverage.

§ 155.715 Eligibility determination process for SHOP for plan years beginning prior to January 1, 2018.

(a) *General requirement.* Before permitting the purchase of coverage in a QHP, the SHOP must determine that the employer or individual who

requests coverage is eligible in accordance with the requirements of § 155.710.

(b) *Applications.* The SHOP must accept a SHOP single employer application form from employers and the SHOP single employee application form from employees wishing to elect coverage through the SHOP, in accordance with the relevant standards of § 155.730.

(c) *Verification of eligibility.* For the purpose of verifying employer and employee eligibility, the SHOP—

(1) Must verify that an individual applicant is identified by the employer as an employee to whom the qualified employer has offered coverage and must otherwise accept the information attested to within the application unless the information is inconsistent with the employer-provided information;

(2) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the applicable application;

(3) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in § 155.710; and

(4) May not perform individual market Exchange eligibility determinations or verifications described in subpart D of this part.

(d) *Eligibility adjustment period.* (1) When the information submitted on the SHOP single employer application is inconsistent with information collected from third-party data sources through the verification process described in § 155.715(c)(2), the SHOP must–

(i) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(ii) Notify the employer of the inconsistency;

(iii) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (d)(1)(ii) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(1)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must—

(A) Notify the employer of its denial of eligibility in accordance with paragraph (e) of this section and of the employer's right to appeal such determination; and

(B) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the notice is sent.

(2) When the information submitted on the SHOP single employee application is inconsistent with information collected from third-party data sources through the verification process described in § 155.715(c)(2), the SHOP must–

(i) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(ii) Notify the individual of the inability to substantiate his or her employee status;

(iii) Provide the employee with a period of 30 days from the date on which the notice described in paragraph (d)(2)(ii) of this section is sent to the employee to either present satisfactory documentary evidence to support the employee's application, or resolve the inconsistency; and

(iv) If, after the 30-day period described in paragraph (d)(2)(iii) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must notify the employee of its denial of eligibility in accordance with paragraph (f) of this section.

(e) *Notification of employer eligibility.* The SHOP must provide an employer requesting eligibility to

purchase coverage with a notice of approval or denial of eligibility and the employer's right to appeal such eligibility determination.

(f) *Notification of employee eligibility.* The SHOP must notify an employee seeking to enroll in a QHP offered through the SHOP of the determination by the SHOP whether the individual is eligible in accordance with § 155.710 and the employee's right to appeal such determination.

(g) *Notification of employer withdrawal from SHOP.* If a qualified employer ceases to purchase coverage through the SHOP, the SHOP must ensure that—

(1) Each QHP terminates the enrollment through the SHOP of the employer's enrollees enrolled in a QHP through the SHOP; and

(2) Each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the termination of coverage prior to such termination. Such notification must also provide information about other potential sources of coverage, including access to individual market coverage through the Exchange.

(h) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.716 is applicable for plan years beginning on or after January 1, 2018.

§ 155.716 Eligibility determination process for SHOP for plan years beginning on or after January 1, 2018.

(a) *General requirement.* The SHOP must determine whether an employer requesting a determination of eligibility to participate in a SHOP is eligible in accordance with the requirements of § 155.710.

(b) *Applications.* The SHOP must accept a SHOP single employer application form from employers, in accordance with the relevant standards of § 155.730.

(c) *Verification of eligibility.* For the purpose of verifying employer eligibility, the SHOP—

(1) May establish, in addition to or in lieu of reliance on the application, additional methods to verify the information provided by the applicant on the applicable application;

(2) Must collect only the minimum information necessary for verification of eligibility in accordance with the eligibility standards described in § 155.710; and

(3) May not perform individual market Exchange eligibility determinations or verifications described in subpart D of this part.

(d) *Eligibility adjustment period.* When the information submitted on the SHOP single employer application is inconsistent with information collected from third-party data sources through the verification process described in paragraph (c)(1) of this section or otherwise received by the SHOP, the SHOP must—

(1) Make a reasonable effort to identify and address the causes of such inconsistency, including through typographical or other clerical errors;

(2) Notify the employer of the inconsistency;

(3) Provide the employer with a period of 30 days from the date on which the notice described in paragraph (d)(2) of this section is sent to the employer to either present satisfactory documentary evidence to support the employer's application, or resolve the inconsistency; and

(4) If, after the 30-day period described in paragraph (d)(2) of this section, the SHOP has not received satisfactory documentary evidence, the SHOP must—

(i) Notify the employer of its denial or termination of eligibility in accordance with paragraph (e) of this section and of the employer's right to appeal such determination; and

(ii) If the employer was enrolled pending the confirmation or verification of eligibility information, discontinue the employer's participation in the SHOP at the end of the month following the month in which the notice is sent.

(e) *Notification of employer eligibility.* The SHOP must provide an employer requesting eligibility to purchase coverage through the SHOP with a notice of approval or denial or termination of eligibility and

the employer's right to appeal such eligibility determination.

(f) *Validity of Eligibility Determination.* An employer's determination of eligibility to participate in SHOP remains valid until the employer makes a change that could end its eligibility under § 155.710(b) or withdraws from participation in the SHOP.

(g) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 155.720 Enrollment of employees into QHPs under SHOP for plan years beginning prior to January 1, 2018.

(a) *General requirements.* The SHOP must process the SHOP single employee applications of qualified employees to the applicable QHP issuers and facilitate the enrollment of qualified employees in QHPs. All references to QHPs in this section refer to QHPs offered through the SHOP.

(b) *Enrollment timeline and process.* The SHOP must establish a uniform enrollment timeline and process for all QHP issuers and qualified employers to follow, which includes the following activities that must occur before the effective date of coverage for qualified employees:

(1) Determination of employer eligibility for purchase of coverage in the SHOP as described in § 155.715;

(2) Qualified employer selection of QHPs offered through the SHOP to qualified employees, consistent with § 155.705(b)(2) and (3);

(3) Provision of a specific timeframe during which the qualified employer can select the level of coverage or QHP offering, as appropriate;

(4) Provision of a specific timeframe for qualified employees to provide relevant information to complete the application process;

(5) Determination and verification of employee eligibility for enrollment through the SHOP; and

(6) Processing enrollment of qualified employees into selected QHPs.

(c) *Transfer of enrollment information.* In order to enroll qualified employees of a qualified employer participating in the SHOP, the SHOP must—

(1) Transmit enrollment information on behalf of qualified employees to QHP issuers in accordance with the timeline and process described in paragraph (b) of this section; and

(2) Follow requirements set forth in § 155.400(c) of this part.

(d) *Payment.* The SHOP must—

(1) Follow requirements set forth in § 155.705(b)(4) of this part; and

(2) Terminate participation of qualified employers that do not comply with the process established in § 155.705(b)(4).

(e) *Notification of effective date.* (1) For plan years beginning before January 1, 2017, the SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP through the SHOP of the effective date of his or her coverage.

(2) For plan years beginning on or after January 1, 2017, the SHOP must ensure that a QHP issuer notifies an enrollee enrolled in a QHP through the SHOP of the effective date of his or her coverage.

(3) When a primary subscriber and his or her dependents live at the same address, a separate notice of the effective date of coverage need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the coverage effective date for the primary subscriber and his or her dependents at that address.

(f) *Records.* The SHOP must receive and maintain for at least 10 years records of enrollment in QHPs, including identification of—

(1) Qualified employers participating in the SHOP; and

(2) Qualified employees enrolled in QHPs.

(g) *Reconcile files.* The SHOP must reconcile enrollment information and employer participation

information with QHPs on no less than a monthly basis.

(h) *Employee termination of coverage from a QHP.* If any employee terminates coverage from a QHP, the SHOP must notify the employee's employer.

(i) *Reporting requirement for tax administration purposes.* The SHOP must report to the IRS employer participation, employer contribution, and employee enrollment information in a time and format to be determined by HHS.

(j) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.721 is applicable for plan years beginning on or after January 1, 2018.

§ 155.721 Record retention and IRS Reporting for plan years beginning on or after January 1, 2018.

(a) *Records.* The SHOP must receive and maintain for at least 10 years records of qualified employers participating in the SHOP.

(b) *Reporting requirement for tax administration purposes.* The SHOP must, at the request of the IRS, report information to the IRS about employer eligibility to participate in SHOP coverage.

(c) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 155.725 Enrollment periods under SHOP for plan years beginning prior to January 1, 2018.

(a) *General requirements.* The SHOP must ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with this section.

(b) *Rolling enrollment in the SHOP.* The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.

(c) *Annual employer election period.* The SHOP must provide qualified employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(1) The method by which the qualified employer makes QHPs available to qualified employees pursuant to § 155.705(b)(2) and (3);

(2) The employer contribution towards the premium cost of coverage;

(3) The level of coverage offered to qualified employees as described in § 155.705(b)(2) and (3); and

(4) The QHP or QHPs offered to qualified employees in accordance with § 155.705.

(d) *Annual employer election period notice.* The SHOP must provide notification to a qualified employer of the annual election period in advance of such period.

(e) *Annual employee open enrollment period.* (1) The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(2) Qualified employers in a Federally-facilitated SHOP must provide qualified employees with an annual open enrollment period of at least one week.

(f) *Annual employee open enrollment period notice.* The SHOP must provide notification to a qualified employee of the annual open enrollment period in advance of such period.

(g) *Newly qualified employees.* (1) In a State Exchange that does not use the Federal platform for SHOP functions, the following rules apply with respect to enrollment and coverage effective dates for newly qualified employees.

(i) The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an

enrollment period beginning on the first day of becoming a qualified employee. A newly qualified employee must have at least 30 days from the beginning of his or her enrollment period to select a QHP. The enrollment period must end no sooner than 15 days prior to the date that any applicable employee waiting period longer than 45 days would end if the employee made a plan selection on the first day of becoming eligible.

(ii) The effective date of coverage for a QHP selection received by the SHOP from a newly qualified employee must always be the first day of a month, and must generally be determined in accordance with paragraph (h) of this section, unless the employee is subject to a waiting period consistent with § 147.116 of this subchapter, in which case the effective date may be on the first day of a later month, but in no case may the effective date fail to comply with § 147.116 of this subchapter.

(iii) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee.

(2) In a Federally-facilitated SHOP or in a State Exchange that uses the Federal platform for SHOP functions, the following rules apply with respect to enrollment and coverage effective dates for newly qualified employees.

(i) The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period with a 30-day enrollment period beginning on the date the qualified employer notifies the SHOP about the newly qualified employee. Qualified employers must notify the SHOP about a newly qualified employee on or before the thirtieth day after the day that the employee becomes a newly qualified employee.

(ii) The effective date of coverage for a QHP selection received by the SHOP from a newly qualified employee is the first day of the month following plan selection, unless the employee is subject to a waiting period consistent with § 147.116 of this subchapter and paragraph (g)(2)(iii) of this section, in which case the effective date will be on the first day of the month following the end of the waiting period, but in no case may the effective date fail to comply with § 147.116 of this subchapter. If a newly qualified employee's waiting period ends on the first day of a month and the employee has already made a plan selection by that date, coverage must take effect on that date. If a newly qualified employee makes a plan selection on the first day of a month and any applicable waiting period has ended by that date, coverage must be effective on the first day of the following month. If a qualified employer with variable hour employees makes regularly having a specified number of hours of service per period, or working full-time, a condition of employee eligibility for coverage offered through the SHOP, any measurement period that the qualified employer elects to use under § 147.116(c)(3)(i) to determine whether an employee meets the applicable eligibility conditions with respect to coverage offered through the SHOP must not exceed 10 months, beginning on any date between the employee's start date and the first day of the first calendar month following the employee's start date.

(iii) Waiting periods in the SHOP are calculated beginning on the date the employee becomes a qualified employee who is otherwise eligible for coverage, regardless of when a qualified employer notifies the SHOP about a newly qualified employee, and must not exceed 60 days in length. Waiting periods must be 0, 15, 30, 45 or 60 days in length.

(h) *Initial and annual open enrollment effective dates.* (1) The SHOP must establish effective dates of coverage for qualified employees enrolling in coverage for the first time, and for qualified employees enrolling during the annual open enrollment period described in paragraph (e) of this section.

(2) For a group enrollment received by the Federally-facilitated SHOP from a qualified employer at the time of an initial group enrollment or renewal: (i) Between the first and fifteenth day of any month, the Federally-facilitated SHOP must ensure a coverage effective

date of the first day of the following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(ii) Between the 16th and last day of any month, the Federally-facilitated SHOP must ensure a coverage effective date of the first day of the second following month unless the employer opts for a later effective date within a quarter for which small group market rates are available.

(i) *Renewal of coverage.* (1) If a qualified employee enrolled in a QHP through the SHOP remains eligible for enrollment through the SHOP in coverage offered by the same qualified employer, the SHOP may provide for a process under which the employee will remain in the QHP selected the previous year, unless—

(i) The qualified employee terminates coverage from such QHP in accordance with standards identified in § 155.430;

(ii) The qualified employee enrolls in another QHP if such option exists; or

(iii) The QHP is no longer available to the qualified employee.

(2) The SHOP may treat a qualified employer offering coverage through the SHOP as offering the same coverage under § 155.705(b)(3) at the same level of contribution under § 155.705(b)(11) unless:

(i) The qualified employer is no longer eligible to offer such coverage through the SHOP;

(ii) The qualified employer elects to offer different coverage or a different contribution through the SHOP;

(iii) The qualified employer withdraws from the SHOP; or

(iv) In the case of a qualified employer offering a single QHP, the single QHP is no longer available through the SHOP.

(j)(1) *Special enrollment periods.* The SHOP must provide special enrollment periods consistent with this section, during which certain qualified employees or a dependent of a qualified employee may enroll in QHPs and enrollees may change QHPs.

(2) The SHOP must provide a special enrollment period for a qualified employee or dependent of a qualified employee who:

(i) Experiences an event described in § 155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in § 155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);

(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or

(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:

(i) Thirty (30) days from the date of a triggering event described in paragraph (j)(2)(i) of this section to select a QHP through the SHOP; and

(ii) Sixty (60) days from the date of a triggering event described in paragraph (j)(2)(ii) or (iii) of this section to select a QHP through the SHOP;

(4) A dependent of a qualified employee is not eligible for a special election period if the employer does not extend the offer of coverage to dependents.

(5) The effective dates of coverage for special enrollment periods are determined using the provisions of § 155.420(b).

(6) Loss of minimum essential coverage is determined using the provisions of § 155.420(e).

(7) Notwithstanding anything to the contrary in § 155.420(d), § 155.420(a)(4) and (d)(2)(i)(A) do not apply to special enrollment periods in the SHOP.

(k) *Limitation.* Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under § 155.705(b)(10).

(l) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.726 is applicable for plan years beginning on or after January 1, 2018.

§ 155.726 Enrollment periods under SHOP for plan years beginning on or after January 1, 2018.

(a) *General requirements.* The SHOP must ensure that issuers offering QHPs through the SHOP adhere to applicable enrollment periods, including special enrollment periods.

(b) *Rolling enrollment in the SHOP.* The SHOP must permit a qualified employer to purchase coverage for its small group at any point during the year. The employer's plan year must consist of the 12-month period beginning with the qualified employer's effective date of coverage, unless the plan is issued in a State that has elected to merge its individual and small group risk pools under section 1312(c)(3) of the Affordable Care Act, in which case the plan year will end on December 31 of the calendar year in which coverage first became effective.

(c) *Special enrollment periods.* (1) The SHOP must ensure that issuers offering QHPs through the SHOP provide special enrollment periods consistent with the section, during which certain qualified employees or dependents of qualified employees may enroll in QHPs and enrollees may change QHPs.

(2) The SHOP must ensure that issuers offering QHPs through a SHOP provide a special enrollment period for a qualified employee or a dependent of a qualified employee who;

(i) Experiences an event described in § 155.420(d)(1) (other than paragraph (d)(1)(ii)), or experiences an event described in § 155.420(d)(2), (4), (5), (7), (8), (9), (10), (11), or (12);

(ii) Loses eligibility for coverage under a Medicaid plan under title XIX of the Social Security Act or a State child health plan under title XXI of the Social Security Act; or

(iii) Becomes eligible for assistance, with respect to coverage under a SHOP, under such Medicaid plan or a State child health plan (including any waiver or demonstration project conducted under or in relation to such a plan).

(3) A qualified employee or dependent of a qualified employee who experiences a qualifying event described in paragraph (j)(2) of this section has:

(i) Thirty (30) days from the date of a triggering event described in paragraph (c)(2)(i) of this section to select a QHP through the SHOP; and

(ii) Sixty (60) days from the date of a triggering event described in paragraph (c)(2)(ii) or (iii) of this section to select a QHP through the SHOP;

(4) A dependent of a qualified employee is not eligible for a special enrollment period if the employer does not extend the offer of coverage to dependents.

(5) The effective dates of coverage for special enrollment periods are determined using the provisions of § 155.420(b).

(6) Loss of minimum essential coverage is determined using the provisions of § 155.420(e).

(d) *Limitation.* Qualified employees will not be able to enroll unless the employer group meets any applicable minimum participation rate implemented under § 155.706(b)(10).

(e) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 155.730 Application standards for SHOP for plan year beginning prior to January 1, 2018.

(a) *General requirements.* Application forms used by the SHOP must meet the requirements set forth in this section.

(b) *Single employer application.* The SHOP must use a single application to determine employer eligibility and to collect information necessary for purchasing coverage. Such application must collect the following—

(1) Employer name and address of employer's locations;

(2) Number of employees;

(3) Employer Identification Number (EIN); and

(4) A list of qualified employees and their taxpayer identification numbers.

(c) *Single employee application.* The SHOP must use a single application for eligibility determination, QHP selection and enrollment for qualified employees and their dependents.

(d) *Model application.* The SHOP may use the model single employer application and the model single employee application provided by HHS.

(e) *Alternative employer and employee application.* The SHOP may use an alternative application if such application is approved by HHS and collects the following:

(1) In the case of the employer application, the information in described in paragraph (b); and

(2) In the case of the employee application, the information necessary to establish eligibility of the employee as a qualified employee and to complete the enrollment of the qualified employee and any dependents to be enrolled.

(f) *Filing.* The SHOP must:

(1) Accept applications from SHOP application filers; and

(2) Provide the tools to file an application via an Internet Web site.

(g) *Additional safeguards.* (1) The SHOP may not provide to the employer any information collected on the employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.

(2) The SHOP is not permitted to collect information on the single employer or single employee application unless that information is necessary to determine SHOP eligibility or effectuate enrollment through the SHOP.

(h) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.731 is applicable for plan years beginning on or after January 1, 2018.

§ 155.731 Application standards for SHOP for plan years beginning on or after January 1, 2018.

(a) *General requirements.* Application forms used by the SHOP must meet the requirements set forth in this section.

(b) *Single employer application.* The SHOP must use a single application to determine employer eligibility. Such application must collect the following—

(1) Employer name and address of employer's locations;

(2) Information sufficient to confirm the employer is a small employer;

(3) Employer Identification Number (EIN); and

(4) Information sufficient to confirm that the employer is offering, at a minimum, all full-time employees coverage in a QHP through a SHOP.

(c) *Model application.* The SHOP may use the model single employer application provided by HHS.

(d) *Alternative employer application.* The SHOP may use an alternative application if such application is approved by HHS and collects the information described in paragraph (b).

(e) *Filing.* The SHOP must:

(1) Accept applications from SHOP application filers; and

(2) Provide the tools to file an employer eligibility application via an internet website.

(f) *Additional safeguards.* (1) The SHOP may not provide to the employer any information collected on an employee application with respect to spouses or dependents other than the name, address, and birth date of the spouse or dependent.

(2) The SHOP is not permitted to collect information on the single employer or on an employee application unless that information is necessary to determine SHOP eligibility or effectuate enrollment through the SHOP.

(g) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 155.735 Termination of SHOP enrollment or coverage for plan years beginning prior to January 1, 2018.

(a) *General requirements.* The SHOP must determine the timing, form, and manner in which coverage or enrollment in a QHP through the SHOP may be terminated.

(b) *Termination of employer group health coverage or enrollment at the request of the employer.* (1) The SHOP must establish policies for advance notice of termination required from the employer and effective dates of termination.

(2) In the Federally-facilitated SHOP, an employer may terminate coverage or enrollment for all enrollees covered by the employer group health plan effective on the last day of any month, provided that the employer has given notice to the Federally-facilitated SHOP on or before the 15th day of any month. If notice is given after the 15th of the month, the Federally-facilitated SHOP may terminate the coverage or enrollment on the last day of the following month.

(c) *Termination of employer group health coverage for non-payment of premiums.* (1) The SHOP must establish policies for termination for nonpayment of premiums, including but not limited to policies regarding due dates for payment of premiums to the SHOP, grace periods, employer and employee notices, and reinstatement provisions.

(2) In an FF–SHOP, for premium payments other than payments for the first month of coverage—

(i) For a given month of coverage, premium payment is due by the first day of the coverage month.

(ii) If premium payment is not received 31 days from the first of the coverage month, the Federally-facilitated SHOP may terminate the qualified employer for lack of payment. The termination would take effect on the last day of the month for which the Federally-facilitated SHOP received full payment.

(iii) If a qualified employer is terminated due to lack of premium payment, but within 30 days following its termination the qualified employer requests reinstatement, pays all premiums owed including any prior premiums owed for coverage during the grace period, and pays the premium for the next month's coverage, the Federally-facilitated SHOP must reinstate the qualified employer in its previous coverage. A qualified employer may be reinstated in the Federally-facilitated SHOP only once per calendar year.

(iv) Enrollees enrolled in continuation coverage required under 29 U.S.C. 1161, *et seq.* through the Federally-facilitated SHOP may not be terminated if timely payment is made to the Federally-facilitated SHOP in an amount that is not less than $50 less than the amount the plan requires to be paid for a period of coverage unless the Federally-facilitated SHOP notifies the enrollee of the amount of the deficiency and the enrollee does not pay the deficiency within 30 days of such notice, pursuant to the notice requirements in § 155.230.

(3) *Payment for COBRA Continuation Coverage.* Nothing in this section modifies existing obligations related to the administration of coverage required under 29 U.S.C. 1161, *et seq.*, as described in 26 CFR part 54.

(d) *Termination of employee or dependent coverage or enrollment.* (1) The SHOP must establish

consistent policies regarding the process for and effective dates of termination of employee or dependent coverage or enrollment in the following circumstances:

(i) The employee or dependent is no longer eligible for coverage under the employer's group health plan;

(ii) The employee requests that the SHOP terminate the coverage of the employee or a dependent of the employee under the employer's group health plan;

(iii) The QHP in which the enrollee is enrolled terminates, is decertified as described in § 155.1080, or its certification as a QHP is not renewed;

(iv) The enrollee changes from one QHP to another during the employer's annual open enrollment period or during a special enrollment period in accordance with § 155.725(j); or

(v) The enrollee's coverage is rescinded in accordance with § 147.128 of this subtitle.

(2) In the FF–SHOP, termination is effective:

(i) In the case of a termination in accordance with paragraphs (d)(1)(i), (ii), (iii), and (v) of this section, termination is effective on the last day of the month in which the Federally-facilitated SHOP receives notice of the event described in paragraph (d)(1)(i), (ii), (iii), or (v) of this section.

(ii) In the case of a termination in accordance with paragraph (d)(1)(iv) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP, including for any retroactive enrollments effectuated under § 155.725(j)(5).

(iii) The FF–SHOP will send qualified employees a notice notifying them in advance of a child dependent's loss of eligibility for dependent child coverage under their plan because of age. The notice will be sent 90 days in advance of the date when the dependent enrollee would lose eligibility for dependent child coverage. The enrollee will also receive a separate termination notice when coverage is terminated, under § 155.735(g).

(e) *Termination of enrollment or coverage tracking and approval.* The SHOP must comply with the standards described in § 155.430(c).

(f) *Applicability date.* The provisions of this section apply to coverage—

(1) Beginning on or after January 1, 2015; and

(2) In any SHOP providing qualified employers with the option described in § 155.705(b)(2) or the option described in § 155.705(b)(4) before January 1, 2015, beginning with the date that option is offered.

(g) *Notice of termination.* Beginning January 1, 2016:

(1) Except as provided in paragraph (g)(3) of this section, if any enrollee's coverage or enrollment through the SHOP is terminated due to non-payment of premiums or due to a loss of the enrollee's eligibility to participate in the SHOP, including where an enrollee loses his or her eligibility because a qualified employer has lost its eligibility, the SHOP must notify the enrollee of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.

(2) Except as provided in paragraph (g)(3) of this section, if an employer group's coverage or enrollment through the SHOP is terminated due to nonpayment of premiums or, where applicable, due to a loss of the qualified employer's eligibility to offer coverage through the SHOP, the SHOP must notify the employer of the termination. Such notice must include the termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent.

(3) Where State law requires a QHP issuer to send the notices described in paragraphs (g)(1) and (2) of this section, a SHOP is not required to send such notices.

(4) When a primary subscriber and his or her dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and his or her dependents at that address.

(h) *Applicability date.* The provisions of this section apply for plan years beginning before January 1, 2018.

§ 155.740 SHOP employer and employee eligibility appeals requirements for plan years beginning prior to January 1, 2018.

(a) *Definitions.* The definitions in §§ 155.20, 155.300, and 155.500 apply to this section.

(b) *General requirements.* (1) A State, establishing an Exchange that provides for the establishment of a SHOP pursuant to § 155.100 must provide an eligibility appeals process for the SHOP. Where a State has not established an Exchange that provides for the establishment of a SHOP pursuant to § 155.100, HHS will provide an eligibility appeals process for the SHOP that meets the requirements of this section and the requirements in paragraph (b)(2) of this section.

(2) The appeals entity must conduct appeals in accordance with the requirements established in this section and §§ 155.505(e) through (h) and 155.510(a)(1) and (2) and (c).

(c) *Employer right to appeal.* An employer may appeal—

(1) A notice of denial of eligibility under § 155.715(e); or

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.715(e).

(d) *Employee right to appeal.* An employee may appeal—

(1) A notice of denial of eligibility under § 155.715(f); or

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.715(f).

(e) *Appeals notice requirement.* Notices of the right to appeal a denial of eligibility under § 155.715(e) or (f) must be written and include—

(1) The reason for the denial of eligibility, including a citation to the applicable regulations; and

(2) The procedure by which the employer or employee may request an appeal of the denial of eligibility.

(f) *Appeal request.* The SHOP and appeals entity must—

(1) Allow an employer or employee to request an appeal within 90 days from the date of the notice of denial of eligibility to—

(i) The SHOP or the appeals entity; or

(ii) HHS, if no State Exchange that provides for establishment of a SHOP has been established;

(2) Accept appeal requests submitted through any of the methods described in § 155.520(a)(1);

(3) Comply with the requirements of § 155.520(a)(2) and (3); and

(4) Consider an appeal request valid if it is submitted in accordance with paragraph (f)(1) of this section.

(g) *Notice of appeal request.* (1) Upon receipt of a valid appeal request, the appeals entity must—

(i) Send timely acknowledgement to the employer, or employer and employee if an employee is appealing, of the receipt of the appeal request, including—

(A) An explanation of the appeals process; and

(B) Instructions for submitting additional evidence for consideration by the appeals entity.

(ii) Promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP.

(2) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer or employee that is appealing that—

(A) The appeal request has not been accepted,

(B) The nature of the defect in the appeal request; and

(C) An explanation that the employer or employee may cure the defect and resubmit the appeal request if it meets the timeliness requirements of paragraph (f) of this section, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section.

(h) *Transmittal and receipt of records.* (1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (g)(2) of this section, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the SHOP; and

(ii) The eligibility record of the employer or employee that is appealing.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (h)(1) of this section to the SHOP that transmitted the records.

(i) *Dismissal of appeal.* The appeals entity—

(1) Must dismiss an appeal if the employer or employee that is appealing—

(i) Withdraws the request in accordance with the standards set forth in § 155.530(a)(1); or

(ii) Fails to submit an appeal request meeting the standards specified in paragraph (f) of this section.

(2) Must provide timely notice to the employer or employee that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal.

(3) May vacate a dismissal if the employer or employee makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(j) *Procedural rights of the employer or employee.* The appeals entity must provide the employer, or the employer and employee if an employee is appealing, the opportunity to submit relevant evidence for review of the eligibility determination.

(k) *Adjudication of SHOP appeals.* SHOP appeals must—

(1) Comply with the standards set forth in § 155.555(i)(1) and (3); and

(2) Consider the information used to determine the employer or employee's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.

(l) *Appeal decisions.* Appeal decisions must—

(1) Be based solely on—

(i) The evidence referenced in paragraph (k)(2) of this section;

(ii) The eligibility requirements for the SHOP under § 155.710(b) or (e), as applicable.

(2) Comply with the standards set forth in § 155.545(a)(2) through (5); and

(3) Be effective as follows:

(i) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through the SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(ii) For employee appeal decisions only, if an employee is found eligible under the decision, then at the employee's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made effective retroactive to the effective date of coverage or enrollment through the SHOP that the employee would have had if the employee had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(iii) If the employer or employee is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

(m) *Notice of appeal decision.* The appeals entity must issue written notice of the appeal decision to the employer, or to the employer and employee if an employee is appealing, and to the SHOP within 90 days of the date the appeal request is received.

(n) *Implementation of SHOP appeal decisions.* The SHOP must promptly implement the appeal decision upon receiving the notice under paragraph (m) of this section.

(o) *Appeal record.* Subject to the requirements of § 155.550, the appeal record must be accessible to the employer, or employer and employee if an employee is appealing, in a convenient format and at a convenient time.

(p) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 155.741 is applicable for plan years beginning on or after January 1, 2018.

§ 155.741 SHOP employer and employee eligibility appeals requirements for plan year beginning on or after January 1, 2018.

(a) *Definitions.* The definitions in §§ 155.20, 155.300, and 155.500 apply to this section.

(b) *General requirements.* (1) A State, establishing an Exchange that provides for the establishment of a SHOP pursuant to § 155.100 must provide an eligibility appeals process for the SHOP. Where a State has not established an Exchange that provides for the establishment of a SHOP pursuant to § 155.100, HHS will provide an eligibility appeals process for the SHOP that meets the requirements of this section and the requirements in paragraph (b)(2) of this section.

(2) The appeals entity must conduct appeals in accordance with the requirements established in this section and §§ 155.505(e) through (h) and 155.510(a)(1) and (2) and (c).

(c) *Employer right to appeal.* An employer may appeal—

(1) A notice of denial or termination of eligibility under § 155.716(e); or

(2) A failure by the SHOP to provide a timely eligibility determination or a timely notice of an eligibility determination in accordance with § 155.716(e).

(d) *Appeals notice requirement.* Notices of the right to appeal a denial of eligibility under § 155.716(e) must be written and include—

(1) The reason for the denial or termination of eligibility, including a citation to the applicable regulations; and

(2) The procedure by which the employer may request an appeal of the denial or termination of eligibility.

(e) *Appeal request.* The SHOP and appeals entity must—

(1) Allow an employer to request an appeal within 90 days from the date of the notice of denial or termination of eligibility to—

(i) The SHOP or the appeals entity; or

(ii) HHS, if no State Exchange that provides for establishment of a SHOP has been established;

(2) Accept appeal requests submitted through any of the methods described in § 155.520(a)(1);

(3) Comply with the requirements of § 155.520(a)(2) and (3); and

(4) Consider an appeal request valid if it is submitted in accordance with paragraph (e)(1) of this section.

(f) *Notice of appeal request.* (1) Upon receipt of a valid appeal request, the appeals entity must—

(i) Send timely acknowledgement to the employer of the receipt of the appeal request, including—

(A) An explanation of the appeals process; and

(B) Instructions for submitting additional evidence for consideration by the appeals entity.

(ii) Promptly notify the SHOP of the appeal, if the appeal request was not initially made to the SHOP.

(2) Upon receipt of an appeal request that is not valid because it fails to meet the requirements of this section, the appeals entity must—

(i) Promptly and without undue delay, send written notice to the employer that is appealing that—

(A) The appeal request has not been accepted,

(B) The nature of the defect in the appeal request; and

(C) An explanation that the employer may cure the defect and resubmit the appeal request if it meets the timeliness requirements of paragraph (e) of this section, or within a reasonable timeframe established by the appeals entity.

(ii) Treat as valid an amended appeal request that meets the requirements of this section.

(g) *Transmittal and receipt of records.* (1) Upon receipt of a valid appeal request under this section, or upon receipt of the notice under paragraph (f)(2) of this section, the SHOP must promptly transmit, via secure electronic interface, to the appeals entity—

(i) The appeal request, if the appeal request was initially made to the SHOP; and

(ii) The eligibility record of the employer that is appealing.

(2) The appeals entity must promptly confirm receipt of records transmitted pursuant to paragraph (g)(1) of this section to the SHOP that transmitted the records.

(h) *Dismissal of appeal.* The appeals entity—

(1) Must dismiss an appeal if the employer that is appealing—

(i) Withdraws the request in accordance with the standards set forth in § 155.530(a)(1); or

(ii) Fails to submit an appeal request meeting the standards specified in paragraph (e) of this section.

(2) Must provide timely notice to the employer that is appealing of the dismissal of the appeal request, including the reason for dismissal, and must notify the SHOP of the dismissal.

(3) May vacate a dismissal if the employer makes a written request within 30 days of the date of the notice of dismissal showing good cause why the dismissal should be vacated.

(i) *Procedural rights of the employer.* The appeals entity must provide the employer the opportunity to submit relevant evidence for review of the eligibility determination.

(j) *Adjudication of SHOP appeals.* SHOP appeals must— (1) Comply with the standards set forth in § 155.555(i)(1) and (3); and

(2) Consider the information used to determine the employer's eligibility as well as any additional relevant evidence submitted during the course of the appeal by the employer or employee.

(k) *Appeal decisions.* Appeal decisions must—

(1) Be based solely on—

(i) The evidence referenced in paragraph (j)(2) of this section;

(ii) The eligibility requirements for the SHOP under § 155.710(b), as applicable.

(2) Comply with the standards set forth in § 155.545(a)(2) through (5)

(3) Be effective as follows:

(i) If an employer is found eligible under the decision, then at the employer's option, the effective date of coverage or enrollment through the SHOP under the decision can either be made retroactive to the effective date of coverage or enrollment through the SHOP that the employer would have had if the employer had been correctly determined eligible, or prospective to the first day of the month following the date of the notice of the appeal decision.

(ii) If the employer is found ineligible under the decision, then the appeal decision is effective as of the date of the notice of the appeal decision.

(l) *Notice of appeal decision.* The appeals entity must issue written notice of the appeal decision to the employer and to the SHOP within 90 days of the date the appeal request is received.

(m) *Implementation of SHOP appeal decisions.* The SHOP must promptly implement the appeal decision upon receiving the notice under paragraph (l) of this section.

(n) *Appeal record.* Subject to the requirements of § 155.550, the appeal record must be accessible to the employer in a convenient format and at a convenient time.

(o) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

SUBPARTS I AND J [RESERVED]

SUBPART K—EXCHANGE FUNCTIONS: CERTIFICATION OF QUALIFIED HEALTH PLANS

§ 155.1000 Certification standards for QHPs.

(a) *Definition.* The following definition applies in this subpart:

Multi-State plan means a health plan that is offered in accordance with section 1334 of the Affordable Care Act.

(b) *General requirement.* The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise.

(c) *General certification criteria.* The Exchange may certify a health plan as a QHP in the Exchange if—

(1) The health insurance issuer provides evidence during the certification process in § 155.1010 that it complies with the minimum certification requirements outlined in subpart C of part 156, as applicable; and

(2) The Exchange determines that making the health plan available is in the interest of the qualified individuals and qualified employers, except that the Exchange must not exclude a health plan—

(i) On the basis that such plan is a fee-for-service plan;

(ii) Through the imposition of premium price controls; or

(iii) On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

(d) *Special rule for SHOP.* Except when a QHP is decertified by the Exchange pursuant to § 155.1080, in a SHOP that certifies QHPs on a calendar-year basis, the certification shall remain in effect for the duration of any plan year beginning in the calendar year for which the QHP was certified, even if the plan year ends after the calendar year for which the QHP was certified.

§ 155.1010 Certification process for QHPs.

(a) *Certification procedures.* The Exchange must establish procedures for the certification of QHPs consistent with § 155.1000(c).

(1) *Completion date.* The Exchange must complete the certification of the QHPs that will be offered during the open enrollment period prior to the beginning of such period, as outlined in § 155.410.

(2) *Ongoing compliance.* The Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements in § 155.1000(c).

(b) *Exchange recognition of plans deemed certified for participation in an Exchange.* Notwithstanding paragraph (a) of this section, an Exchange must recognize as certified QHPs:

(1) A multi-State plan certified by and under contract with the U.S. Office of Personnel Management.

(2) A CO–OP QHP as described in subpart F of part 156 and deemed as certified under § 156.520(e).

§ 155.1020 QHP issuer rate and benefit information.

(a) *Receipt and posting of rate increase justification.* The Exchange must ensure that a QHP issuer submits a justification for a rate increase for a QHP prior to the implementation of such an increase, except for multi-State plans, for which the U.S. Office of Personnel Management will provide a process for the submission of rate increase justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its Web site as required under § 156.210. To ensure consumer transparency, the Exchange must also provide access to the justification on its Internet Web site described in § 155.205(b).

(b) *Rate increase consideration.* (1) The Exchange must consider rate increases in accordance with section 1311(e)(2) of the Affordable Care Act, which includes consideration of the following:

(i) A justification for a rate increase prior to the implementation of the increase;

(ii) Recommendations provided to the Exchange by the State in accordance with section 2794(b)(1)(B) of the PHS Act; and

(iii) Any excess of rate growth outside the Exchange as compared to the rate of such growth inside the Exchange.

(2) This paragraph does not apply to multi-State plans for which the U.S. Office of Personnel Management will provide a process for rate increase consideration.

(c) *Benefit and rate information.* The Exchange must receive the information described in this paragraph, at least annually, from QHP issuers for each QHP in a form and manner to be specified by HHS. Information about multi-State plans may be provided in a form and manner determined by the U.S. Office of Personnel Management. The information identified in this paragraph is:

(1) Rates;

(2) Covered benefits; and

(3) Cost-sharing requirements.

§ 155.1030 QHP certification standards related to advance payments of the premium tax credit and cost-sharing reductions.

(a) *Review of plan variations for cost-sharing reductions.* (1) An Exchange must ensure that each

issuer that offers, or intends to offer a health plan at any level of coverage in the individual market on the Exchange submits the required plan variations for the health plan as described in § 156.420 of this subchapter. The Exchange must certify that the plan variations meet the requirements of § 156.420.

(2) The Exchange must provide to HHS the actuarial values of each QHP and silver plan variation, calculated under § 156.135 of this subchapter, in the manner and timeframe established by HHS.

(b) *Information for administering advance payments of the premium tax credit and advance payments of cost-sharing reductions.* (1) The Exchange must collect and review annually the rate allocation and the actuarial memorandum that an issuer submits to the Exchange under § 156.470 of this subchapter, to ensure that the allocation meets the standards set forth in § 156.470(c) and (d) of this subchapter.

(2) The Exchange must submit, in the manner and timeframe established by HHS, to HHS the approved allocations and actuarial memorandum underlying the approved allocations for each health plan at any level of coverage or standalone dental plan offered, or intended to be offered in the individual market on the Exchange.

(3) The Exchange must use the methodology specified in the annual HHS notice of benefit and payment parameters to calculate advance payment amounts for cost-sharing reductions, and must transmit the advance payment amounts to HHS, in accordance with § 156.340(a) of this subchapter.

(4) HHS may use the information provided to HHS by the Exchange under this section for oversight of advance payments of cost-sharing reductions and premium tax credits.

(c) *Multi-State plans.* The U.S. Office of Personnel Management will ensure compliance with the standards referenced in this section for multi-State plans, as defined in § 155.1000(a).

§ 155.1040 Transparency in coverage.

(a) *General requirement.* The Exchange must collect information relating to coverage transparency as described in § 156.220 of this subtitle from QHP issuers, and from multi-State plans in a time and manner determined by the U.S. Office of Personnel Management.

(b) *Use of plain language.* The Exchange must determine whether the information required to be submitted and made available under paragraph (a) of this section is provided in plain language.

(c) *Transparency of cost-sharing information.* The Exchange must monitor whether a QHP issuer has made cost-sharing information available in a timely manner upon the request of an individual as required by § 156.220(d) of this subtitle.

§ 155.1045 Accreditation timeline.

(a) *Timeline.* The Exchange must establish a uniform period following certification of a QHP within which a QHP issuer that is not already accredited must become accredited as required by § 156.275 of this subchapter, except for multi-state plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-state plans.

(b) *Federally-facilitated Exchange.* The accreditation timeline used in federally-facilitated Exchanges follows:

(1) During certification for an issuer's initial year of QHP certification (for example, in 2013 for the 2014 coverage year), a QHP issuer without existing commercial, Medicaid, or Exchange health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is applying to offer coverage must have scheduled or plan to schedule a review of QHP policies and procedures of the applying QHP issuer with a recognized accrediting entity.

(2) Prior to a QHP issuer's second year and third year of QHP certification (for example, in 2014 for the 2015 coverage year and 2015 for the 2016 coverage year), a QHP issuer must be accredited by a recognized accrediting entity on the policies and procedures that are applicable to their Exchange products, or a QHP issuer must have commercial or Medicaid health plan accreditation granted by a recognized accrediting entity for the same State in which the issuer is offering Exchange coverage and the administrative policies and procedures underlying that accreditation must be the same or similar to the

administrative policies and procedures used in connection with the QHP.

(3) Prior to the QHP issuer's fourth year of QHP certification and in every subsequent year of certification (for example, in 2016 for the 2017 coverage year and forward), a QHP issuer must be accredited in accordance with § 156.275 of this subchapter.

§ 155.1050 Establishment of Exchange network adequacy standards.

(a) An Exchange must ensure that the provider network of each QHP meets the standards specified in § 156.230 of this subtitle, except for multi-State plans.

(b) The U.S. Office of Personnel Management will ensure compliance with the standards specified in § 156.230 of this subtitle for multi-State plans.

(c) A QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under § 156.235(c) of this subtitle.

§ 155.1055 Service area of a QHP.

The Exchange must have a process to establish or evaluate the service areas of QHPs to ensure such service areas meet the following minimum criteria:

(a) The service area of a QHP covers a minimum geographical area that is at least the entire geographic area of a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers.

(b) The service area of a QHP has been established without regard to racial, ethnic, language, health status-related factors specified under section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost or medically-underserved populations.

§ 155.1065 Stand-alone dental plans.

(a) *General requirements.* The Exchange must allow the offering of a limited scope dental benefits plan through the Exchange, if—

(1) The plan meets the requirements of section 9832(c)(2)(A) of the Code and 2791(c)(2)(A) of the PHS Act; and

(2) The plan covers at least the pediatric dental essential health benefit as defined in section 1302(b)(1)(J) of the Affordable Care Act, provided that, with respect to this benefit, the plan satisfies the requirements of section 2711 of the PHS Act; and

(3) The plan and issuer of such plan meets QHP certification standards, including § 155.1020(c), except for any certification requirement that cannot be met because the plan covers only the benefits described in paragraph (a)(2) of this section.

(b) *Offering options.* The Exchange may allow the dental plan to be offered—

(1) As a stand-alone dental plan; or

(2) In conjunction with a QHP.

(c) *Sufficient capacity.* An Exchange must consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage.

(d) *QHP Certification standards.* If a plan described in paragraph (a) of this section is offered through an Exchange, another health plan offered through such Exchange must not fail to be treated as a QHP solely because the plan does not offer coverage of benefits offered through the stand-alone plan that are otherwise required under section 1302(b)(1)(J) of the Affordable Care Act.

§ 155.1075 Recertification of QHPs.

(a) *Recertification process.* Except with respect to multi-State plans and CO–OP QHPs, an Exchange must establish a process for recertification of QHPs that, at a minimum, includes a review of the general certification criteria as outlined in § 155.1000(c). Upon determining the recertification status of a QHP, the Exchange must notify the QHP issuer.

(b) *Timing.* The Exchange must complete the QHP recertification process no later than 2 weeks prior to the beginning of the open enrollment date at § 155.410(e)(2) of the applicable calendar year.

§ 155.1080 Decertification of QHPs.

(a) *Definition.* The following definition applies to this section:

Decertification means the termination by the Exchange of the certification status and offering of a QHP.

(b) *Decertification process.* Except with respect to multi-State plans and CO–OP QHPs, the Exchange must establish a process for the decertification of QHPs, which, at a minimum, meets the requirements in this section.

(c) *Decertification by the Exchange.* The Exchange may at any time decertify a health plan if the Exchange determines that the QHP issuer is no longer in compliance with the general certification criteria as outlined in § 155.1000(c).

(d) *Appeal of decertification.* The Exchange must establish a process for the appeal of a decertification of a QHP.

(e) *Notice of decertification.* Upon decertification of a QHP, the Exchange must provide notice of decertification to all affected parties, including:

(1) The QHP issuer;

(2) Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in § 155.420;

(3) HHS; and

(4) The State department of insurance.

§ 155.1090 Request for reconsideration.

(a) *Request for reconsideration of denial of certification specific to a Federally-facilitated Exchange*—(1) *Request for reconsideration.* The Federally-facilitated Exchanges will permit an issuer that has submitted a complete application to a Federally-facilitated Exchange for certification of a health plan as a QHP and is denied certification to request reconsideration of such action.

(2) *Form and manner of request.* An issuer submitting a request for reconsideration under paragraph (a)(1) of this section must submit a written request for reconsideration to HHS, in the form and manner specified by HHS, within 7 calendar days of the date of the written notice of denial of certification. The issuer must include any and all documentation the issuer wishes to provide in support of its request with its request for reconsideration.

(3) *HHS reconsideration decision.* HHS will provide the issuer with a written notice of the reconsideration decision. The decision will constitute HHS's final determination.

(b) [Reserved]

SUBPART L [RESERVED]

SUBPART M—OVERSIGHT AND PROGRAM INTEGRITY STANDARDS FOR STATE EXCHANGES

§ 155.1200 General program integrity and oversight requirements.

(a) *General requirement.* A State Exchange must:

(1) Keep an accurate accounting of Exchange receipts and expenditures in accordance with generally accepted accounting principles (GAAP).

(2) Monitor and report to HHS on Exchange related activities.

(3) Collect and report to HHS performance monitoring data.

(b) *Reporting.* The State Exchange must, at least annually, provide to HHS, in a manner specified by HHS and by applicable deadlines specified by HHS, the following data and information:

(1) A financial statement presented in accordance with GAAP,

(2) Information showing compliance with Exchange requirements under this part 155 through submission of annual reports,

(3) Performance monitoring data, and

(4) If the Exchange is collecting premiums under § 155.240, a report on instances in which it did not reduce an enrollee's premium by the amount of the advance payment of the premium tax credit in accordance with § 155.340(g)(1) and (2).

(c) *External audits.* The State Exchange must engage an independent qualified auditing entity which follows generally accepted government auditing standards (GAGAS) to perform an annual independent external financial and programmatic audit and must make such information available to HHS for review. The State Exchange must:

(1) Provide to HHS the results of the annual external audit; and

(2) Inform HHS of any material weakness or significant deficiency identified in the audit and must develop and inform HHS of a corrective action plan for such material weakness or significant deficiency;

(3) Make public a summary of the results of the external audit.

(d) *External audit standard.* The State Exchange must ensure that independent audits of State Exchange financial statements and program activities in paragraph (c) of this section address:

(1) Compliance with paragraph (a)(1) of this section;

(2) Compliance with subparts D and E of this part 155, or other requirements under this part 155 as specified by HHS;

(3) Processes and procedures designed to prevent improper eligibility determinations and enrollment transactions, as applicable;

(4) Compliance with eligibility and enrollment standards through sampling, testing, or other equivalent auditing procedures that demonstrate the accuracy of eligibility determinations and enrollment transactions; and

(5) Identification of errors that have resulted in incorrect eligibility determinations, as applicable.

§ 155.1210 Maintenance of records.

(a) *General.* The State Exchange must maintain and must ensure its contractors, subcontractors, and agents maintain for 10 years, documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, which are sufficient to do the following:

(1) Accommodate periodic auditing of the State Exchange's financial records; and

(2) Enable HHS or its designee(s) to inspect facilities, or otherwise evaluate the State-Exchange's compliance with Federal standards.

(b) *Records.* The State Exchange and its contractors, subcontractors, and agents must ensure that the records specified in paragraph (a) of this section include, at a minimum, the following:

(1) Information concerning management and operation of the State Exchange's financial and other record keeping systems;

(2) Financial statements, including cash flow statements, and accounts receivable and matters pertaining to the costs of operations;

(3) Any financial reports filed with other Federal programs or State authorities;

(4) Data and records relating to the State Exchange's eligibility verifications and determinations, enrollment transactions, appeals, and plan variation certifications; and

(5) Qualified health plan contracting (including benefit review) data and consumer outreach and Navigator grant oversight information.

(c) *Availability.* A State Exchange must make all records and must ensure its contractors, subcontractors, and agents must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

SUBPART N—STATE FLEXIBILITY

§ 155.1300 Basis and purpose.

(a) *Statutory basis.* This subpart implements provisions of section 1332 of the Affordable Care Act, relating to Waivers for State Innovation, which the Secretary may authorize for plan years beginning on or after January 1, 2017. Section 1332 of the Affordable Care Act requires the Secretary to issue regulations that provide for all of the following:

(1) A process for public notice and comment at the State level, including public hearings, sufficient to ensure a meaningful level of public input.

(2) A process for the submission of an application that ensures the disclosure of all of the following:

(i) The provisions of law that the State involved seeks to waive.

(ii) The specific plans of the State to ensure that the waiver will meet all requirements specified in section 1332.

(3) A process for the provision of public notice and comment after a waiver application is received by the Secretary, that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance.

(4) A process for the submission of reports to the Secretary by a State relating to the implementation of a waiver.

(5) A process for the periodic evaluation by the Secretary of programs under waivers.

(b) *Purpose.* This subpart sets forth certain procedural requirements for Waivers for State Innovation under section 1332 of the Affordable Care Act.

§ 155.1302 Coordinated waiver process.

(a) *Coordination with applications for waivers under other Federal laws.* A State may submit a single application to the Secretary for a waiver under section 1332 of the Affordable Care Act and a waiver under one or more of the existing waiver processes applicable under titles XVIII, XIX, and XXI of the Act, or under any other Federal law relating to the provision of health care items or services, provided that such application is consistent with the procedures described in this part, the procedures for demonstrations under section 1115 of the Act, if applicable, and the procedures under any other applicable Federal law under which the State seeks a waiver.

(b) *Coordinated process for section 1332 waivers.* A State seeking a section 1332 waiver must submit a waiver application to the Secretary. Any application submitted to the Secretary that requests to waive sections 36B, 4980H, or 5000A of the Code, in accordance with section 1332(a)(2)(D) of the Affordable Care Act, shall upon receipt be transmitted by the Secretary to the Secretary of the Treasury to be reviewed in accordance with 31 CFR Part 33.

§ 155.1304 Definitions.

For the purposes of this subpart:

Complete application means an application that has been submitted and for which the Secretary and the Secretary of the Treasury, as applicable, have made a preliminary determination that it includes all required information and satisfies all requirements that are described in § 155.1308(f).

Public notice means a notice issued by a government agency or legislative body that contains sufficient detail to notify the public at large of a proposed action consistent with § 155.1312.

Section 1332 waiver means a Waiver for State Innovation under section 1332 of the Affordable Care Act.

§ 155.1308 Application procedures.

(a) *Acceptable formats for applications.* Applications for initial approval of a section 1332 waiver shall be submitted in electronic format to the Secretary.

(b) *Application timing.* Applications for initial approval of a section 1332 waiver must be submitted sufficiently in advance of the requested effective date to allow for an appropriate implementation timeline.

(c) *Preliminary review.* Each application for a section 1332 waiver will be subject to a preliminary review by the Secretary and the Secretary of the Treasury, as applicable, who will make a preliminary determination that the application is complete. A submitted application will not be deemed received until the Secretary and the Secretary of the Treasury, as applicable, have made the preliminary determination that the application is complete.

(1) The Secretary and the Secretary of the Treasury, as applicable, will complete the preliminary review of the application within 45 days after it is submitted.

(2) If the Secretary and the Secretary of the Treasury, as applicable, determine that the application is not complete, the Secretary will send the State a written notice of the elements missing from the application.

(3) The preliminary determination that an application is complete does not preclude a finding during the 180-day Federal decision-making period that a necessary element of the application is missing or insufficient.

(d) *Notification of preliminary determination.* Upon making the preliminary determination that an application is complete, as defined in this part, the Secretary will send the State a written notice informing the State that the Secretary and the Secretary of the Treasury, as applicable, have made such a preliminary determination. That date will also mark the beginning of the Federal public notice process and the 180-day Federal decision-making period.

(e) *Public notice of completed application.* Upon receipt of a complete application for an initial section 1332 waiver, the Secretary will—

(1) Make available to the public the application, and all related State submissions, including all supplemental information received from the State following the receipt of a complete application for a section 1332 waiver.

(2) Indicate the status of the application.

(f) *Criteria for a complete application.* An application for initial approval of a section 1332 waiver will not be considered complete unless the application meets all of the following conditions:

(1) Complies with paragraphs (a) through (f) of this section.

(2) Provides written evidence of the State's compliance with the public notice requirements set forth in § 155.1312, including a description of the key issues raised during the State public notice and comment period.

(3) Provides all of the following:

(i) A comprehensive description of the State legislation and program to implement a plan meeting the requirements for a waiver under section 1332 of PPACA. In analyzing whether the State has satisfied the requirement under section 1332(b)(2)(A) of PPACA that the State enact a law authorizing a waiver under section 1332 of PPACA, the Secretary and the Secretary of the Treasury, as applicable, may consider existing State legislation combined with duly-enacted State regulation or an executive order so long as the State legislation provides statutory authority to enforce PPACA provisions or the State plan;

(ii) A copy of the enacted State legislation that provides the State with authority to implement the proposed waiver, as required under section 1332(a)(1)(C) of the Affordable Care Act;

(iii) A list of the provisions of law that the State seeks to waive including a description of the reason for the specific requests; and

(iv) The analyses, actuarial certifications, data, assumptions, targets, and other information set forth in paragraph (f)(4) of this section sufficient to provide the Secretary and the Secretary of the Treasury, as applicable, with the necessary data to determine that the State's proposed waiver satisfies the general requirements for approval under section 1332(b)(1) of the Affordable Care Act consistent with the provisions of this paragraph;

(A) As required under section 1332(b)(1)(A) of the Affordable Care Act (the comprehensive coverage requirement), will provide coverage that is at least as comprehensive as the coverage defined in section 1302(b) of the Affordable Care Act and offered through Exchanges established under the Affordable Care Act as certified by the Office of the Actuary of the Centers for Medicare & Medicaid Services based on sufficient data from the State and from comparable States about their experience with programs created by the Affordable Care Act and the provisions of the Affordable Care Act that the State seeks to waive. To satisfy the comprehensive coverage requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the coverage under the State plan is forecasted to be at least as comprehensive overall for residents of the State as coverage absent the waiver;

(B) As required under section 1332(b)(1)(B) of the Affordable Care Act (the affordability requirement), will provide coverage and cost sharing protections against excessive out-of-pocket spending that are at least as affordable as the provisions of Title I of the Affordable Care Act would provide. To satisfy the affordability requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the coverage under the State plan is forecasted to be at least as affordable overall for State residents as coverage absent the waiver;

(C) As required under section 1332(b)(1)(C) of the Affordable Care Act (the scope of coverage requirement), will provide coverage to at least a comparable number of its residents as the provisions of Title I of the Affordable Care Act would provide. To satisfy the scope of coverage requirement, the Secretary and the Secretary of the Treasury, as applicable, must determine that the State plan will provide coverage to a comparable number of State residents under the waiver as would have coverage absent the waiver; and

(D) As prohibited under section 1332(b)(1)(D) of the Affordable Care Act (the Federal deficit requirement), will not increase the Federal deficit.

(4) Contains the following supporting information:

(i) *Actuarial analyses and actuarial certifications.* Actuarial analyses and actuarial certifications to support the State's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, and the scope of coverage requirement;

(ii) *Economic analyses.* Economic analyses to support the State's estimates that the proposed waiver will comply with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement, including:

(A) A detailed 10-year budget plan that is deficit neutral to the Federal government, as prescribed by section 1332(a)(1)(B)(ii) of the Affordable Care Act, and includes all costs under the waiver, including administrative costs and other costs to the Federal government, if applicable; and

(B) A detailed analysis regarding the estimated impact of the waiver on health insurance coverage in the State.

(iii) *Data and assumptions.* The data and assumptions used to demonstrate that the State's proposed waiver is in compliance with the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement, including:

(A) Information on the age, income, health expenses and current health insurance status of the relevant State population; the number of employers by number of employees and whether the employer offers insurance; cross-tabulations of these

variables; and an explanation of data sources and quality; and

(B) An explanation of the key assumptions used to develop the estimates of the effect of the waiver on coverage and the Federal budget, such as individual and employer participation rates, behavioral changes, premium and price effects, and other relevant factors.

(iv) *Implementation timeline.* A detailed draft timeline for the State's implementation of the proposed waiver.

(v) *Additional information.* Additional information supporting the State's proposed waiver, including:

(A) An explanation as to whether the waiver increases or decreases the administrative burden on individuals, insurers, and employers, and if so, how and why;

(B) An explanation of how the waiver will affect the implementation of the provisions of the Affordable Care Act which the State is not requesting to waive in the State and at the Federal level;

(C) An explanation of how the waiver will affect residents who need to obtain health care services out-of-State, as well as the States in which such residents may seek such services;

(D) If applicable, an explanation as to how the State will provide the Federal government with all information necessary to administer the waiver at the Federal level; and

(E) An explanation of how the State's proposal will address potential individual, employer, insurer, or provider compliance, waste, fraud and abuse within the State or in other States.

(vi) *Reporting targets.* Quarterly, annual, and cumulative targets for the comprehensive coverage requirement, the affordability requirement, the scope of coverage requirement and the Federal deficit requirement.

(vii) *Other information.* Other information consistent with guidance provided by the Secretary and the Secretary of the Treasury, as applicable.

(g) *Additional supporting information.* (1) During the Federal review process, the Secretary may request additional supporting information from the State as needed to address public comments or to address issues that arise in reviewing the application.

(2) Requests for additional information, and responses to such requests, will be made available to the public in the same manner as information described in § 155.1316(b).

§ 155.1312 State public notice requirements.

(a) *General.* (1) Prior to submitting an application for a new section 1332 waiver to the Secretary for review and consideration, a State must provide a public notice and comment period sufficient to ensure a meaningful level of public input for the application for a section 1332 waiver.

(2) Such public notice and comment period shall include, for a State with one or more Federally-recognized Indian tribes within its borders, a separate process for meaningful consultation with such tribes.

(b) *Public notice and comment period.* The State shall make available at the beginning of the public notice and comment period, through its Web site or other effective means of communication, and shall update as appropriate, a public notice that includes all of the following:

(1) A comprehensive description of the application for a section 1332 waiver to be submitted to the Secretary including information and assurances related to all statutory requirements and other information consistent with guidance provided by the Secretary and the Secretary of the Treasury, as applicable.

(2) Information relating to where copies of the application for a section 1332 waiver are available for public review and comment.

(3) Information relating to how and where written comments may be submitted and reviewed by the public, and the timeframe during which comments will be accepted.

(4) The location, date, and time of public hearings that will be convened by the State to seek public input on the application for a section 1332 waiver.

(c) *Public hearings.* (1) After issuing the public notice and prior to submitting an application for a new section 1332 waiver, a State must conduct public hearings regarding the State's application.

(2) Such public hearings shall provide an interested party the opportunity to learn about and comment on the contents of the application for a section 1332 waiver.

(d) *Submission of initial application.* After the State public notice and comment period has concluded, the State may submit an application to the Secretary for an initial waiver in accordance with the requirements set forth in § 155.1308.

§ 155.1316 Federal public notice and approval process.

(a) *General.* The Federal public notice and approval process begins on the first business day after the Secretary and the Secretary of the Treasury, as applicable, determine that all elements for a complete application were documented and submitted to the Secretary.

(b) *Public notice and comment period.* (1) Following a determination that a State's application for a section 1332 waiver is complete, the Secretary and the Secretary of the Treasury, as applicable, will provide for a public notice and comment period that is sufficient to ensure a meaningful level of public input and that does not impose requirements that are in addition to, or duplicative of, requirements imposed under the Administrative Procedures Act, or requirements that are unreasonable or unnecessarily burdensome with respect to State compliance.

(2) At the beginning of the Federal notice and comment period, the Secretary will make available through its Web site and otherwise, and shall update as appropriate, public notice that includes all of the following:

(i) The complete application for a section 1332 waiver, updates for the status of the State's application, and any supplemental materials received from the State prior to and during the Federal public notice and comment period.

(ii) Information relating to where copies of the application for a section 1332 waiver are available for public review and comment.

(iii) Information relating to how and where written comments may be submitted and reviewed by the public, and the timeframe during which comments will be accepted.

(iv) Any public comments received during the Federal public notice and comment period.

(c) *Approval of a section 1332 waiver application.* The final decision of the Secretary and the Secretary of the Treasury, as applicable, on a State application for a section 1332 waiver will be issued by the Secretary no later than 180 days after the determination by the Secretary and the Secretary of the Treasury, as applicable, that a complete application was received in accordance with § 155.1308.

§ 155.1318 Modification from the normal public notice requirements during an emergent situation.

(a) The Secretary and the Secretary of the Treasury may modify, in part, the State public notice requirements under § 155.1312(a)(1), (b), (c), and (d) and the Federal public notice procedures under § 155.1316(b) to expedite a decision on a proposed section 1332 waiver request during an emergent situation, when a delay would undermine or compromise the purpose of the proposed waiver request and be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to comprehensive coverage, consumers' access to health care, or human life.

(b) A State must meet all of the following criteria to request a modification under paragraph (a) of this section:

(1) The State must request a modification under paragraph (a) of this section, in the form and manner specified by the Secretaries.

(2) The State must have acted in good faith, and in a diligent, timely, and prudent manner in the preparation of the request for a modification under paragraph (a) of this section, and the waiver application request, as applicable.

(3) The State must, as applicable, detail in its request for a modification from State-level notice procedures under paragraph (a) of this section the justification for the request as it relates to the emergent situation and the alternative public notice procedures it proposes to implement at the State level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergency circumstances underlying the State's request for a modification.

(4) The State must, as applicable, detail in its request for a modification from Federal-level notice procedures under paragraph (a) of this section the justification for the request and the alternative public notice procedures it requests to be implemented at the Federal level.

(5) The State must explain in its request for a modification from State-level notice procedures under paragraph (a) of this section how the emergent circumstances underlying its request result from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to comprehensive coverage, consumers' access to health care, or human life could not reasonably have been foreseen and how a delay would undermine or compromise the purpose of the waiver and be contrary to the interests of consumers.

(c) The Secretary and the Secretary of the Treasury will evaluate a State's request for a modification under paragraph (a) of this section and issue their modification determination within approximately 15 calendar days after the request is received.

(d) The Secretary will publish on the CMS website any modification determinations within 15 calendar days of the Secretary and the Secretary of the Treasury making such a determination, as well as the approved revised timeline for public comment under the approved alternative State or Federal public notice procedures, as applicable.

(e) The State must publish on its website any modification requests and determinations within 15 calendar days of receipt of the determination, as well as the approved revised timeline for public comment under the alternative State or Federal public notice procedures, as applicable.

(f) The State must, as applicable, implement the alternative public notice procedures at the State level if the State's modification request is approved and, if required, amend the waiver application request.

(g) The Secretary and the Secretary of the Treasury will consider circumstances to be emergent when they could not have been reasonably foreseen. The Secretary and the Secretary of the Treasury will assess ''reasonable foreseeability'' based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number of days a State may have been aware of such issues.

§ 155.1320 Monitoring and compliance.

(a) *General.* (1) Following the issuance of a final decision to approve a section 1332 waiver by the Secretary and the Secretary of the Treasury, as applicable, a State must comply with all applicable Federal laws and regulations, unless expressly waived. A State must, within the timeframes specified in law and regulation come into compliance with any changes in Federal law and regulation affecting section 1332 waivers, unless the provision being changed is expressly waived.

(2) The Secretary and the Secretary of the Treasury will examine compliance with Federal and regulatory requirements consistent with § 155.1308(f)(3)(iv) when conducting implementation reviews under paragraph (b) of this section.

(b) *Implementation reviews.* (1) The terms and conditions of an approved section 1332 waiver will provide that the State will perform periodic reviews of the implementation of the section 1332 waiver.

(2) The Secretary and the Secretary of the Treasury, as applicable, will review documented

complaints that a State is failing to comply with requirements specified in the terms and conditions of any approved section 1332 waiver.

(3) The Secretary and the Secretary of the Treasury, as applicable, will promptly share with a State any complaint that the Secretary and the Secretary of the Treasury has received and will also provide notification of any applicable monitoring and compliance issues.

(c) *Post award.* Within at least 6 months after the implementation date of a section 1332 waiver and annually thereafter, a State must hold a public forum to solicit comments on the progress of a section 1332 waiver. The State must hold the public forum at which members of the public have an opportunity to provide comments and must provide a summary of the forum to the Secretary as part of the quarterly report specified in § 155.1324(a) that is associated with the quarter in which the forum was held, as well as in the annual report specified in § 155.1324(b) that is associated with the year in which the forum was held.

(1) *Notification requirements for public forum*. The State must publish the date, time, and location of the public forum in a prominent location on the State's public web site, at least 30 days prior to the date of the planned public forum.

(2) *Modification from the normal post award requirements during an emergent situation.* (i) The Secretary and the Secretary of the Treasury may modify, in part, State post award requirements under this paragraph (c)(2) for an approved section 1332 waiver request during an emergent situation when the application of the post award public notice requirements would be contrary to the interests of consumers. These flexibilities are limited to emergent situations, including natural disasters; public health emergencies; or other emergent situations that threaten consumers' access to comprehensive coverage, consumers' access to health care, or human life.

(ii) A State must meet all of the following criteria to request a modification under paragraph (c) of this section:

(A) The State must request a modification under paragraph (c)(2) of this section, in the form and manner specified by the Secretaries.

(B) The State must have acted in good faith, and in a diligent, timely, and prudent manner to comply with the monitoring and compliance requirement under the waiver and the terms and conditions of the agreement between the Secretary and the Secretary of the Treasury, as applicable, and the State to implement a section 1332 waiver and to submit and prepare the request for a modification under paragraph (c)(2) of this section.

(C) The State must detail in its request for a modification under paragraph (c)(2) of this section the alternative post award public notice procedures it proposes to implement at the State level, including public hearings, that are designed to provide the greatest opportunity and level of meaningful public input from impacted stakeholders that is practicable given the emergency circumstances underlying the State's request for a modification.

(D) The Secretary and the Secretary of the Treasury will evaluate a State's request for a modification under paragraph (c)(2) of this section and issue their modification determination within approximately 15 calendar days after the request is received.

(E) The State must publish on its website any modification requests and determinations within 15 calendar days of receipt of the determination, as well as information on the approved revised timeline for the State's post award public notice procedures, as applicable.

(F) The State must explain in its request for a modification under paragraph (c)(2) of this section how the emergent circumstances underlying its request results from a natural disaster; public health emergency; or other emergent situations that threaten consumers' access to comprehensive coverage, consumers' access to health care, or human life and could not reasonably have been foreseen and how the application of the post award

public notice requirements would be contrary to the interests of consumers.

(iii) The Secretary and the Secretary of the Treasury will consider circumstances to be emergent when they could not have been reasonably foreseen. The Secretary and the Secretary of the Treasury will assess "reasonable foreseeability" based on the specific issues that a section 1332 waiver proposes to address and other relevant factors, and will not make this assessment based solely on the number of days a State may have been aware of such issues.

(d) *Terminations and suspensions.* The Secretary and the Secretary of the Treasury, as applicable, reserve the right to suspend or terminate a section 1332 waiver in whole or in part, at any time before the date of expiration, whenever the Secretary or the Secretary of the Treasury, as applicable, determines that a State has materially failed to comply with the terms of a section 1332 waiver.

(e) *Closeout costs.* If all or part of a section 1332 waiver is terminated or suspended, or if a portion of a section 1332 waiver is withdrawn, Federal funding is limited to normal closeout costs associated with an orderly termination, suspension, or withdrawal, including service costs during any approved transition period, and administrative costs of disenrolling participants.

(f) *Federal evaluators.* (1) A State must fully cooperate with the Secretary, the Secretary of the Treasury, as applicable, or an independent evaluator selected by the Secretary or the Secretary of the Treasury, as applicable, to undertake an independent evaluation of any component of a section 1332 waiver.

(2) As part of this required cooperation, a State must submit all requested data and information to the Secretary, the Secretary of the Treasury, as applicable, or the independent evaluator.

§ 155.1322 Pass-through funding for approved waivers.

(a) *Pass-through funding.* With respect to a State's approved section 1332 waiver, under which, due to the structure of the approved State waiver plan, individuals and small employers in the State would not qualify for or would qualify for a reduced amount of premium tax credit under section 36B of the Internal Revenue Code, small business tax credit under section 45R of the Internal Revenue Code, or cost-sharing reductions under ACA part I of subtitle E for which they would otherwise be eligible, the Secretary and the Secretary of the Treasury shall provide for an alternative means by which the aggregate amount of such credits or reductions that would have been paid on behalf of participants in the Exchanges had the State not received such waiver shall be paid to the State for purposes of implementing the approved State waiver plan. Such amount shall be determined annually by the Secretary and the Secretary of the Treasury, taking into consideration the experience of other States with respect to participation in an Exchange and credits and reductions provided under such provisions to residents of the other States. This amount can be updated to reflect applicable changes in Federal or State law.

(b) [Reserved]

§ 155.1324 State reporting requirements.

(a) *Quarterly reports.* A State must submit quarterly reports to the Secretary in accordance with the terms and conditions of the State's section 1332 waiver. These quarterly reports must include, but are not limited to, reports of any ongoing operational challenges and plans for and results of associated corrective actions.

(b) *Annual reports.* A State must submit an annual report to the Secretary documenting all of the following:

(1) The progress of the section 1332 waiver.

(2) Data on compliance with section 1332(b)(1)(A) through (D) of the Affordable Care Act.

(3) A summary of the annual post-award public forum, held in accordance with § 155.1320(c), including all public comments received at such forum regarding the progress of the section 1332 waiver and action taken in response to such concerns or comments.

(4) Other information consistent with the State's approved terms and conditions.

(c) *Submitting and publishing annual reports.* A State must submit a draft annual report to the Secretary no later than 90 days after the end of each waiver year, or as specified in the waiver's terms and conditions.

(1) Within 60 days of receipt of comments from the Secretary, a State must submit to the Secretary the final annual report for the waiver year.

(2) The draft and final annual reports are to be published on a State's public web site within 30 days of submission to and approval by the Secretary, respectively.

§ 155.1328 Periodic evaluation requirements.

(a) The Secretary and the Secretary of the Treasury, as applicable, shall periodically evaluate the implementation of a program under a section 1332 waiver consistent with § 155.1308(f)(3)(iv) and any terms and conditions governing the section 1332 waiver.

(b) Each periodic evaluation must include a review of the annual report or reports submitted by the State in accordance with § 155.1324 that relate to the period of time covered by the evaluation.

§ 155.1330 Waiver amendment.

(a) *Amendment to an approved section 1332 waiver.* A State may request an amendment to an approved section 1332 waiver from the Secretary and the Secretary of the Treasury. A section 1332 waiver amendment is considered a change to a section 1332 waiver plan that is not otherwise allowable under the terms and conditions of an approved waiver, a change that could impact any of the section 1332 statutory guardrails or a change to the program design for an approved waiver. A State is not authorized to implement any aspect of the proposed amendment without prior approval by the Secretary and the Secretary of the Treasury.

(b) [Reserved]

§ 155.1332 Waiver extension.

(a) *Extension.* A State may request continuation of an approved section 1332 waiver, and such request shall be deemed granted unless the Secretary and the Secretary of the Treasury, within 90 days after the date of submission of a complete waiver extension request to the Secretary and the Secretary of the Treasury, either denies such request in writing or informs the State in writing with respect to any additional information that is needed in order to make a final determination with respect to the request.

(b) [Reserved]

SUBPART O—QUALITY REPORTING STANDARDS FOR EXCHANGES

§ 155.1400 Quality rating system.

The Exchange must prominently display quality rating information for each QHP on its website, in accordance with § 155.205(b)(1)(v), in a form and manner specified by HHS.

§ 155.1405 Enrollee satisfaction survey system.

The Exchange must prominently display results from the Enrollee Satisfaction Survey for each QHP on its website, in accordance with § 155.205(b)(1)(iv), in a form and manner specified by HHS.

SUBPART P—IMPROPER PAYMENT PRE-TESTING AND ASSESSMENT (IPPTA) FOR STATE-BASED EXCHANGES [*Not included in this compilation*]

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

Authority: 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, and 26 U.S.C. 36B.

SUBPART A—GENERAL PROVISIONS

§ 156.10 Basis and scope.

(a) *Basis.* (1) This part is based on the following sections of title I of the Affordable Care Act:

(i) 1301. QHP defined.

(ii) 1302. Essential health benefits requirements.

(iii) 1303. Special rules.

(iv) 1304. Related definitions.

(v) 1311. Affordable choices of health benefit plans.

(vi) 1312. Consumer choice.

(vii) 1313. Financial integrity.

(viii) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(ix) 1322. Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers.

(x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.

(xi) 1334. Multi-State plans.

(xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.

(xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.

(xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.

(xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) *Scope.* This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.

§ 156.20 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Actuarial value (AV) means the percentage paid by a health plan of the percentage of the total allowed costs of benefits.

Applicant has the meaning given to the term in § 155.20 of this subchapter.

Base-benchmark plan means the plan that is selected by a State from the options described in § 156.100(a) of this subchapter, or a default benchmark plan, as described in § 156.100(c) of this subchapter, prior to any adjustments made pursuant to the benchmark standards described in § 156.110 of this subchapter.

Benefit design standards means coverage that provides for all of the following:

(1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the

Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing has the meaning given to the term in § 155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in § 155.20 of this subtitle.

Delegated entity means any party, including an agent or broker, that enters into an agreement with a QHP issuer to provide administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Downstream entity means any party, including an agent or broker, that enters into an agreement with a delegated entity or with another downstream entity for purposes of providing administrative or health care services related to the agreement between the delegated entity and the QHP issuer. The term "downstream entity" is intended to reach the entity that directly provides administrative services or health care services to qualified individuals, qualified employers, or qualified employees and their dependents.

Enrollee satisfaction survey vendor means an organization that has relevant survey administration experience (for example, CAHPS® surveys), organizational survey capacity, and quality control procedures for survey administration.

EHB-benchmark plan means the standardized set of essential health benefits that must be met by a QHP, as defined in § 155.20 of this section, or other issuer as required by § 147.150 of this subchapter.

Essential health benefits package or EHB package means the scope of covered benefits and associated limits of a health plan offered by an issuer that provides at least the ten statutory categories of benefits, as described in § 156.110(a) of this subchapter; provides the benefits in the manner described in § 156.115 of this subchapter; limits cost sharing for such coverage as described in § 156.130; and subject to offering catastrophic plans as described in section 1302(e) of the Affordable Care Act, provides distinct levels of coverage as described in § 156.140 of this subchapter.

Federally-facilitated SHOP has the meaning given to the term in § 155.20 of this subchapter.

Group health plan has the meaning given to the term in § 144.103 of this subtitle.

Health insurance coverage has the meaning given to the term in § 144.103 of this subtitle.

Health insurance issuer or issuer has the meaning given to the term in § 144.103 of this subtitle.

Issuer group means all entities treated under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 as a member of the same controlled group of corporations as (or under common control with) a health insurance issuer, or issuers affiliated by the common use of a nationally licensed service mark.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

Percentage of the total allowed costs of benefits means the anticipated covered medical spending for EHB coverage (as defined in § 156.110(a) of this subchapter) paid by a health plan for a standard population, computed in accordance with the plan's cost-sharing, divided by the total anticipated allowed charges for EHB coverage provided to a standard population, and expressed as a percentage.

Plan has the meaning given the term in § 144.103 of this subchapter.

Plan year has the meaning given to the term in § 155.20 of this subchapter.

Qualified employer has the meaning given to the term in § 155.20 of this subchapter.

Qualified health plan has the meaning given to the term in § 155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in § 155.20 of this subchapter.

Qualified individual has the meaning given to the term in § 155.20 of this subchapter.

Registered user of the enrollee satisfaction survey data warehouse means enrollee satisfaction survey vendors, QHP issuers, and Exchanges authorized to access CMS's secure data warehouse to submit survey data and to preview survey results prior to public reporting.

§ 156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in § 155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in § 155.1065 of this subtitle), or other issuers identified by an Exchange.

(b) *Requirement for State-based Exchange user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by a State-based Exchange under § 155.160 of this subchapter.

(c) *Requirement for Exchange user fees.* (1) To support the functions of Federally-facilitated Exchanges, a participating issuer offering a plan through a Federally-facilitated Exchange must remit a user fee to HHS each month, in the timeframe and manner established by HHS, equal to the product of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for Federally-facilitated Exchanges for the applicable benefit year and the monthly premium charged by the issuer for each policy under the plan where enrollment is through a Federally-facilitated Exchange.

(2) To support the functions of State Exchanges on the Federal platform, unless the State Exchange and HHS agree on an alternative mechanism to collect the funds, a participating issuer offering a plan through a State Exchange on the Federal Exchange platform for certain Exchange functions described in § 155.200 of this subchapter, as specified in a Federal platform agreement, must remit a user fee to HHS, in the timeframe and manner established by HHS, equal to the product of the sum of the monthly user fee rate specified in the annual HHS notice of benefit and payment parameters for State Exchanges on the Federal platform for the applicable benefit year, multiplied by the monthly premium charged by the issuer for each policy under the plan where enrollment is through the State-based Exchange on the Federal platform.

(d) *Adjustment of Exchange user fees.* (1) A participating issuer offering a plan through a Federally-facilitated Exchange or State Exchange on the Federal platform may qualify for an adjustment of the Federally-facilitated Exchange user fee specified in paragraph (c)(1) of this section or the State Exchange on the Federal platform user fee specified in paragraph (c)(2) of this section, to the extent that the participating issuer—

(i) Made payments for contraceptive services on behalf of a third party administrator pursuant to 26 CFR 54.9815–2713A(b)(2)(ii) or 29 CFR 2590.715–2713A(b)(2)(ii); or

(ii) Seeks an adjustment in the Federally-facilitated Exchange user fee with respect to a third party administrator that, following receipt of a copy of the self-certification referenced in 26 CFR 54.9815– 2713A(a)(4) or 29 CFR 2590.715– 2713A(a)(4), made or arranged for payments for contraceptive services pursuant to 26 CFR 54.9815–2713A(b)(2)(i) or (ii) or 29 CFR 2590.715–2713A(b)(2)(i) or (ii).

(2) For a participating issuer described in paragraph (d)(1) of this section to receive an adjustment of a user fee under this section—

(i) The participating issuer must submit to HHS, in the manner and timeframe specified by HHS, in the year following the calendar year in which the contraceptive services for which payments were made pursuant to 26 CFR 54.9815–2713A(b)(2) or 29 CFR 2590.715–2713A(b)(2) were provided —

(A) Identifying information for the participating issuer and each third party administrator that received a copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR

2590.715–2713A(a)(4) or with respect to which the participating issuer seeks an adjustment of the user fee specified in paragraph (c)(1) or (2) of this section, as applicable, whether or not the participating issuer was the entity that made the payments for contraceptive services;

(B) Identifying information for each self-insured group health plan with respect to which a copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR 2590.715–2713A(a)(4) was received by a third party administrator and with respect to which the participating issuer seeks an adjustment of the user fee specified in paragraph (c)(1) or (2) of this section, as applicable; and

(C) For each such self-insured group health plan, the total dollar amount of the payments that were made pursuant to 26 CFR 54.9815–2713A(b)(2) or 29 CFR 2590.715–2713A(b)(2) for contraceptive services that were provided during the applicable calendar year. If such payments were made by the participating issuer directly as described in paragraph (d)(1)(i) of this section, the total dollar amount should reflect the amount of the payments made by the participating issuer; if the third party administrator made or arranged for such payments, as described in paragraph (d)(1)(ii) of this section, the total dollar amount should reflect the amount reported to the participating issuer by the third party administrator.

(ii) Each third party administrator that intends to seek an adjustment on behalf of a participating issuer of the Federally-facilitated Exchange user fee or the State-based Exchange on the Federal platform user fee based on payments for contraceptive services, must submit to HHS a notification of such intent, in a manner specified by HHS, by the 60th calendar day following the date on which the third party administrator receives the applicable copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR 2590.715–2713A(a)(4).

(iii) Each third party administrator identified in paragraph (d)(2)(i)(A) of this section must submit to HHS, in the manner and timeframe specified by HHS, in the year following the calendar year in which the contraceptive services for which payments were made pursuant to 26 CFR 54.9815– 2713A(b)(2) or 29 CFR 2590.715– 2713A(b)(2) were provided—

(A) Identifying information for the third party administrator and the participating issuer;

(B) Identifying information for each self-insured group health plan with respect to which a copy of the self-certification referenced in 26 CFR 54.9815–2713A(a)(4) or 29 CFR 2590.715–2713A(a)(4) was received by the third party administrator and with respect to which the participating issuer seeks an adjustment of the user fee specified in paragraph (c)(1) or (2) of this section, as applicable;

(C) The total number of participants and beneficiaries in each such self-insured group health plan during the applicable calendar year;

(D) For each such self-insured group health plan with respect to which the third party administrator made payments pursuant to 26 CFR 54.9815– 2713A(b)(2) or 29 CFR 2590.715– 2713A(b)(2) for contraceptive services, the total dollar amount of such payments that were provided during the applicable calendar year. If such payments were made by the participating issuer directly as described in paragraph (d)(1)(i) of this section, the total dollar amount should reflect the amount reported to the third party administrator by the participating issuer; if the third party administrator made or arranged for such payments, as described in paragraph (d)(1)(ii) of this section, the total dollar amount should reflect the amount of the payments made by or on behalf of the third party administrator; and

(E) An attestation that the payments for contraceptive services were made in compliance with 26 CFR 54.9815–2713A(b)(2) or 29 CFR 2590.715–2713A(b)(2).

(3) If the requirements set forth in paragraph (d)(2) of this section are met, the participating issuer will be provided a reduction in its obligation to pay the user fee specified in paragraph (c)(1) or (2) of this section, as applicable, equal in value to the sum of the following:

(i) The total dollar amount of the payments for contraceptive services submitted by the applicable third party administrators, as described in paragraph (d)(2)(iii)(D) of this section.

(ii) An allowance for administrative costs and margin. The allowance will be no less than 10 percent of the total dollar amount of the payments for contraceptive services specified in paragraph (d)(3)(i) of this section. HHS will specify the allowance for a particular calendar year in the annual HHS notice of benefit and payment parameters.

(4) If the amount of the adjustment under paragraph (d)(3) of this section is greater than the amount of the participating issuer's obligation to pay the user fee specified in paragraph (c)(1) or (2) of this section, as applicable, in a particular month, the participating issuer will be provided a credit in succeeding months in the amount of the excess.

(5) Within 60 days of receipt of any adjustment of a user fee under this section, a participating issuer must pay each third party administrator with respect to which it received any portion of such adjustment an amount that is no less than the portion of the adjustment attributable to the total dollar amount of the payments for contraceptive services submitted by the third party administrator, as described in paragraph (d)(2)(iii)(D) of this section. No such payment is required with respect to the allowance for administrative costs and margin described in paragraph (d)(3)(ii) of this section. This paragraph does not apply if the participating issuer made the payments for contraceptive services on behalf of the third party administrator, as described in paragraph (d)(1)(i) of this section, or is in the same issuer group as the third party administrator.

(6) A participating issuer that receives an adjustment in the user fee specified in paragraph (c)(1) or (2) of this section for a particular calendar year must maintain for 10 years following that year, and make available upon request to HHS, the Office of the Inspector General, the Comptroller General, and their designees, documentation demonstrating that it timely paid each third party administrator with respect to which it received any such adjustment any amount required to be paid to the third party administrator under paragraph (d)(5) of this section.

(7) A third party administrator of a plan with respect to which an adjustment of the user fee specified in paragraph (c)(1) or (2) of this section is received under this section for a particular calendar year must maintain for 10 years following that year, and make available upon request to HHS, the Office of the Inspector General, the Comptroller General, and their designees, all of the following documentation:

(i) A copy of the self-certification referenced in 26 CFR 54.9815– 2713A(a)(4) or 29 CFR 2590.715– 2713A(a)(4) for each self-insured plan with respect to which an adjustment is received.

(ii) Documentation demonstrating that the payments for contraceptive services were made in compliance with 26 CFR 54.9815–2713A(b)(2) or 29 CFR 2590.715–2713A(b)(2).

(iii) Documentation supporting the total dollar amount of the payments for contraceptive services submitted by the third party administrator, as described in paragraph (d)(2)(iii)(D) of this section.

§ 156.80 Single risk pool.

(a) *Individual market.* A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service

Act and offered by such issuer in the individual market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(b) *Small group market.* A health insurance issuer must consider the claims experience of all enrollees in all health plans (other than grandfathered health plans) subject to section 2701 of the Public Health Service Act and offered by such issuer in the small group market in a state, including those enrollees who do not enroll in such plans through the Exchange, to be members of a single risk pool.

(c) *Merger of the individual and small group markets.* A state may require the individual and small group insurance markets within a state to be merged into a single risk pool if the state determines appropriate. A state that requires such merger must submit to CMS information on its election in accordance with the procedures described in § 147.103 of this subchapter.

(d) *Index rate*—(1) *In general.* A health insurance issuer must establish an index rate that is effective January 1 of each calendar year for a State market described in paragraphs (a) through (c) of this section.

(i) The index rate must be based on the total combined claims costs for providing essential health benefits within the single risk pool of that State market.

(ii) The index rate must be adjusted on a market-wide basis for the State based on the total expected market-wide payments and charges under the risk adjustment program and Exchange user fees (expected to be remitted under § 156.50(b) or (c) and (d) as applicable, plus the dollar amount under § 156.50(d)(3)(i) and (ii) expected to be credited against user fees payable for that State market).

(iii) The premium rate for all of the health insurance issuer's plans in the relevant State market must use the applicable market-wide adjusted index rate, subject only to the plan-level adjustments permitted in paragraph (d)(2) of this section.

(2) *Permitted plan-level adjustments to the index rate.* For plan years or policy years beginning on or after January 1, 2014, a health insurance issuer may vary premium rates for a particular plan from its market-wide index rate for a relevant state market based only on the following actuarially justified plan-specific factors:

(i) The actuarial value and cost-sharing design of the plan.

(ii) The plan's provider network, delivery system characteristics, and utilization management practices.

(iii) The benefits provided under the plan that are in addition to the essential health benefits. These additional benefits must be pooled with similar benefits within the single risk pool and the claims experience from those benefits must be utilized to determine rate variations for plans that offer those benefits in addition to essential health benefits.

(iv) Administrative costs, excluding Exchange user fees.

(v) With respect to catastrophic plans, the expected impact of the specific eligibility categories for those plans.

(3) *Calibration.* The issuer must calibrate the plan-adjusted index rate for its plans within the single risk pool to correspond to an age rating factor of 1.0, a geographic rating factor of 1.0, and a tobacco use rating factor of 1.0, in a manner specified by the Secretary in guidance, to ensure that any rating variation under § 147.102 of this subchapter may be accurately applied with respect to a particular plan or coverage. The calibration must be applied uniformly to all plans within the single risk pool of the State market and cannot vary by plan.

(4) *Frequency of index rate and plan-level adjustments.* (i) A health insurance issuer may not establish an index rate and make the market-wide adjustments pursuant to paragraph (d)(1) of this section, make the plan-level adjustments pursuant to paragraph (d)(2) of this section, or calibrate the plan-adjusted index rate for its plans pursuant to paragraph (d)(3) of this section more or less

frequently than annually, except as provided in paragraph (d)(4)(ii) of this section.

(ii) A health insurance issuer in the small group market (not including a merged market) may establish index rates and make the marketwide adjustments under paragraph (d)(1) of this section, make the plan-level adjustments under paragraph (d)(2) of this section, and calibrate the plan-adjusted index rate for its plans pursuant to paragraph (d)(3) of this section, no more frequently than quarterly. Any changes to rates must have effective dates of January 1, April 1, July 1, or October 1. Such rates may only apply to coverage issued or renewed on or after the rate effective date and will apply for the entire plan year of the group health plan.

(e) *Grandfathered health plans in the individual and small group market.* A state law requiring grandfathered health plans described in § 147.140 of this subchapter to be included in a single risk pool described in paragraphs (a) through (c) of this section does not apply.

(f) *Applicability date.* The provisions of this section apply for plan years (as that term is defined in § 144.103 of this subchapter) in the group market, and for policy years (as that term is defined in § 144.103 of this subchapter) in the individual market, beginning on or after January 1, 2014.

SUBPART B—STANDARDS FOR ESSENTIAL HEALTH BENEFITS, ACTUARIAL VALUE, AND COST SHARING

§ 156.100 State selection of benchmark plan for plan years beginning prior to January 1, 2020.

For plan years beginning before January 1, 2020, each State may identify a base-benchmark plan according to the selection criteria described below:

(a) *State selection of base-benchmark plan.* The options from which a base-benchmark plan may be selected by the State are the following:

(1) *Small group market health plan.* The largest health plan by enrollment in any of the three largest small group insurance products by enrollment, as defined in § 159.110 of this subpart, in the State's small group market as defined in § 155.20 of this subchapter.

(2) *State employee health benefit plan.* Any of the largest three employee health benefit plan options by enrollment offered and generally available to State employees in the State involved.

(3) *FEHBP plan.* Any of the largest three national Federal Employees Health Benefits Program (FEHBP) plan options by aggregate enrollment that is offered to all health-benefits-eligible federal employees under 5 USC 8903.

(4) *HMO.* The coverage plan with the largest insured commercial non- Medicaid enrollment offered by a health maintenance organization operating in the State.

(b) *EHB-benchmark selection standards.* In order to become an EHB-benchmark plan as defined in § 156.20 of this subchapter, a state-selected base-benchmark plan must meet the requirements for coverage of benefits and limits described in § 156.110 of this subpart; and

(c) *Default base-benchmark plan.* If a State does not make a selection using the process described in this section, the default base-benchmark plan will be the largest plan by enrollment in the largest product by enrollment in the State's small group market.

(d) *Applicability date:* For plan years beginning on or after January 1, 2020, § 156.111 applies in place of this section.

§ 156.105 Determination of EHB for multistate plans.

A multi-state plan must meet benchmark standards set by the U.S. Office of Personnel Management.

§ 156.110 EHB-benchmark plan standards.

An EHB-benchmark plan must meet the following standards:

(a) *EHB coverage.* Provide coverage of at least the following categories of benefits:

(1) Ambulatory patient services.

(2) Emergency services.

(3) Hospitalization.

(4) Maternity and newborn care.

(5) Mental health and substance use disorder services, including behavioral health treatment.

(6) Prescription drugs.

(7) Rehabilitative and habilitative services and devices.

(8) Laboratory services.

(9) Preventive and wellness services and chronic disease management.

(10) Pediatric services, including oral and vision care.

(b) *Coverage in each benefit category.* A base-benchmark plan not providing any coverage in one or more of the categories described in paragraph (a) of this section, must be supplemented as follows:

(1) *General supplementation methodology.* A base-benchmark plan that does not include items or services within one or more of the categories described in paragraph (a) of this section must be supplemented by the addition of the entire category of such benefits offered under any other benchmark plan option described in § 156.100(a) of this subpart unless otherwise described in this subsection.

(2) *Supplementing pediatric oral services.* A base-benchmark plan lacking the category of pediatric oral services must be supplemented by the addition of the entire category of pediatric oral benefits from one of the following:

(i) The FEDVIP dental plan with the largest national enrollment that is described in and offered to federal employees under 5 U.S.C. 8952; or

(ii) The benefits available under that State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(3) *Supplementing pediatric vision services.* A base-benchmark plan lacking the category of pediatric vision services must be supplemented by the addition of the entire category of pediatric vision benefits from one of the following:

(i) The FEDVIP vision plan with the largest national enrollment that is offered to federal employees under 5 USC 8982; or

(ii) The benefits available under the State's separate CHIP plan, if a separate CHIP plan exists, to the eligibility group with the highest enrollment.

(c) *Supplementing the default base-benchmark plan.* A default base-benchmark plan as defined in § 156.100(c) of this subpart that lacks any categories of essential health benefits will be supplemented by HHS in the following order, to the extent that any of the plans offer benefits in the missing EHB category:

(1) The largest plan by enrollment in the second largest product by enrollment in the State's small group market, as defined in § 155.20 of this subchapter (except for pediatric oral and vision benefits);

(2) The largest plan by enrollment in the third largest product by enrollment in the State's small group market, as defined in § 155.20 of this subchapter (except for pediatric oral and vision benefits);

(3) The largest national FEHBP plan by enrollment across States that is offered to federal employees under 5 USC 8903 (except for pediatric oral and vision benefits);

(4) The plan described in paragraph (b)(2)(i) of this section for pediatric oral care benefits; and

(5) The plan described in paragraph (b)(3)(i) of this section for pediatric vision care benefits.

(d) *Non-discrimination.* Not include discriminatory benefit designs that contravene the non-discrimination standards defined in § 156.125 of this subpart.

(e) *Balance.* Ensure an appropriate balance among the EHB categories to ensure that benefits are not unduly weighted toward any category.

(f) *Determining habilitative services.* If the base-benchmark plan does not include coverage for habilitative services, the State may determine which services are included in that category.

§ 156.111 State selection of EHB-benchmark plan for plan years beginning on or after January 1, 2020.

(a) Subject to paragraphs (b), (c), (d) and (e) of this section, for plan years beginning on or after January 1, 2020, a State may change its EHB-benchmark plan by:

(1) Selecting the EHB-benchmark plan that another State used for the 2017 plan year under § 156.100 and § 156.110;

(2) Replacing one or more categories of EHBs established at § 156.110(a) in the State's EHB-benchmark plan used for the 2017 plan year with the same category or categories of EHB from the EHB-benchmark plan that another State used for the 2017 plan year under § 156.100 and § 156.110; or

(3) Otherwise selecting a set of benefits that would become the State's EHB-benchmark plan.

(b) A State's EHB-benchmark plan must:

(1) *EHB coverage.* Provide coverage of items and services for at least the categories of benefits at § 156.110(a), including an appropriate balance of coverage for these categories of benefits.

(2) *Scope of benefits.* (i) Provide a scope of benefits equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan, defined as either:

(A) One of the selecting State's 10 base-benchmark plan options established at § 156.100, and available for the selecting State's selection for the 2017 plan year; or

(B) The largest health insurance plan by enrollment within one of the five largest large group health insurance products by enrollment in the State, as product and plan are defined at § 144.103 of this subchapter, provided that:

(*1*) The product has at least 10 percent of the total enrollment of the five largest large group health insurance products in the State;

(*2*) The plan provides minimum value, as defined under § 156.145;

(*3*) The benefits are not excepted benefits, as established under § 146.145(b), and § 148.220 of this subchapter; and

(*4*) The benefits in the plan are from a plan year beginning after December 31, 2013.

(ii) Not exceed the generosity of the most generous among a set of comparison plans, including:

(A) The State's EHB-benchmark plan used for the 2017 plan year, and

(B) Any of the State's base-benchmark plan options for the 2017 plan year described in § 156.100(a)(1), supplemented as necessary under § 156.110.

(iii) Not have benefits unduly weighted towards any of the categories of benefits at § 156.110(a);

(iv) Provide benefits for diverse segments of the population, including women, children, persons with disabilities, and other groups; and

(v) Not include discriminatory benefit designs that contravene the nondiscrimination standards defined in § 156.125.

(c) The State must provide reasonable public notice and an opportunity for public comment on the State's selection of an EHB-benchmark plan that includes

posting a notice on its opportunity for public comment with associated information on a relevant State website.

(d) A State must notify HHS of the selection of a new EHB-benchmark plan by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan.

(1) If the State does not make a selection by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan, or its benchmark plan selection does not meet the requirements of this section and section 1302 of the ACA, the State's EHB-benchmark plan for the applicable plan year will be that State's EHB-benchmark plan applicable for the prior year.

(2) [Reserved]

(e) A State changing its EHB-benchmark plan under this section must submit documents in a format and manner specified by HHS by the first Wednesday in May of the year that is 2 years before the effective date of the new EHB-benchmark plan. These must include:

(1) A document confirming that the State's EHB-benchmark plan definition complies with the requirements under paragraphs (a), (b) and (c) of this section, including information on which selection option under paragraph (a) of this section the State is using, and whether the State is using another State's EHB-benchmark plan;

(2) An actuarial certification and an associated actuarial report from an actuary, who is a member of the American Academy of Actuaries, in accordance with generally accepted actuarial principles and methodologies, that affirms:

(i) That the State's EHB-benchmark plan provides a scope of benefits that is equal to, or greater than, to the extent any supplementation is required to provide coverage within each EHB category at § 156.110(a), the scope of benefits provided under a typical employer plan, as defined at (b)(2)(i) of this section; and

(ii) That the State's EHB-benchmark plan does not exceed the generosity of the most generous among the plans listed in paragraphs (b)(2)(ii)(A) and (B) of this section.

(3) The State's EHB-benchmark plan document that reflects the benefits and limitations, including medical management requirements, a schedule of benefits and, if the State is selecting its EHB-benchmark plan using the option in paragraph (a)(3) of this section, a formulary drug list in a format and manner specified by HHS; and

(4) Other documentation specified by HHS, which is necessary to operationalize the State's EHB-benchmark plan.

§ 156.115 Provision of EHB.

(a) Provision of EHB means that a health plan provides benefits that—

(1) Are substantially equal to the EHB-benchmark plan including:

(i) Covered benefits;

(ii) Limitations on coverage including coverage of benefit amount, duration, and scope; and

(iii) Prescription drug benefits that meet the requirements of § 156.122 of this subpart;

(2) With the exception of the EHB category of coverage for pediatric services, do not exclude an enrollee from coverage in an EHB category.

(3) With respect to the mental health and substance use disorder services, including behavioral health treatment services, required under § 156.110(a)(5), comply with the requirements under section 2726 of the Public Health Service Act and its implementing regulations.

(4) Include preventive health services described in § 147.130 of this subchapter.

(5) With respect to habilitative services and devices—

(i) Cover health care services and devices that help a person keep, learn, or improve skills

and functioning for daily living (habilitative services). Examples include therapy for a child who is not walking or talking at the expected age. These services may include physical and occupational therapy, speech-language pathology and other services for people with disabilities in a variety of inpatient and/ or outpatient settings;

(ii) Do not impose limits on coverage of habilitative services and devices that are less favorable than any such limits imposed on coverage of rehabilitative services and devices; and

(iii) For plan years beginning on or after January 1, 2017, do not impose combined limits on habilitative and rehabilitative services and devices.

(6) For plan years beginning on or after January 1, 2016, for pediatric services that are required under § 156.110(a)(10), provide coverage for enrollees until at least the end of the month in which the enrollee turns 19 years of age.

(b) An issuer of a plan offering EHB may substitute benefits for those provided in the EHB-benchmark plan under the following conditions—

(1) The issuer substitutes a benefit that:

(i) Is actuarially equivalent to the benefit that is being replaced as determined in paragraph (b)(4) of this section; and

(ii) Is not a prescription drug benefit.

(2) An issuer may substitute a benefit within the same EHB category, unless prohibited by applicable State requirements. Substitution of benefits between EHB categories is not permitted.

(3) The plan that includes substituted benefits must:

(i) Continue to comply with the requirements of paragraph (a) of this section, including by providing benefits that are substantially equal to the EHB-benchmark plan;

(ii) Provide an appropriate balance among the EHB categories such that benefits are not unduly weighted toward any category; and

(iii) Provide benefits for diverse segments of the population.

(4) The issuer submits to the State evidence of actuarial equivalence that is:

(i) Certified by a member of the American Academy of Actuaries;

(ii) Based on an analysis performed in accordance with generally accepted actuarial principles and methodologies;

(iii) Based on a standardized plan population; and

(iv) Determined without taking cost-sharing into account.

§ 156.120 Collection of data to define essential health benefits.

(a) *Definitions.* The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at § 144.103 of this subchapter, which may be delivered through the purchase of insurance or otherwise.

Health plan has the meaning given to the term ‘‘Portal Plan’’ in § 159.110 of this subchapter.

State has the meaning given to that term in § 155.20 of this subchapter.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include only quantitative treatment limitations. A permanent exclusion of all benefits for a particular condition or disorder is not a treatment limitation.

(b) *Reporting requirement.* A State that selects a base-benchmark plan or an issuer that offers a default base-benchmark plan in accordance with § 156.100

must submit to HHS the following information in a form and manner, and by a date, determined by HHS:

(1) Administrative data necessary to identify the health plan;

(2) Data and descriptive information for each plan on the following items:

(i) All health benefits in the plan;

(ii) Treatment limitations;

(iii) Drug coverage; and

(iv) Exclusions.

§ 156.122 Prescription drug benefits.

(a) A health plan does not provide essential health benefits unless it:

(1) Subject to the exception in paragraph (b) of this section, covers at least the greater of:

(i) One drug in every United States Pharmacopeia (USP) category and class; or

(ii) The same number of prescription drugs in each category and class as the EHB-benchmark plan;

(2) Submits its formulary drug list to the Exchange, the State or OPM; and

(3) For plans years beginning on or after January 1, 2017, uses a pharmacy and therapeutics (P&T) committee that meets the following standards.

(i) *Membership standards.* The P&T committee must:

(A) Have members that represent a sufficient number of clinical specialties to adequately meet the needs of enrollees.

(B) Consist of a majority of individuals who are practicing physicians, practicing pharmacists and other practicing health care professionals who are licensed to prescribe drugs.

(C) Prohibit any member with a conflict of interest with respect to the issuer or a pharmaceutical manufacturer from voting on any matters for which the conflict exists.

(D) Require at least 20 percent of its membership to have no conflict of interest with respect to the issuer and any pharmaceutical manufacturer.

(ii) *Meeting standards.* The P&T committee must:

(A) Meet at least quarterly.

(B) Maintain written documentation of the rationale for all decisions regarding formulary drug list development or revision.

(iii) Formulary drug list establishment and management. The P&T committee must:

(A) Develop and document procedures to ensure appropriate drug review and inclusion.

(B) Base clinical decisions on the strength of scientific evidence and standards of practice, including assessing peer-reviewed medical literature, pharmacoeconomic studies, outcomes research data, and other such information as it determines appropriate.

(C) Consider the therapeutic advantages of drugs in terms of safety and efficacy when selecting formulary drugs.

(D) Review policies that guide exceptions and other utilization management processes, including drug utilization review, quantity limits, and therapeutic interchange.

(E) Evaluate and analyze treatment protocols and procedures related to the plan's formulary at least annually.

(F) Review and approve all clinical prior authorization criteria, step therapy

protocols, and quantity limit restrictions applied to each covered drug.

(G) Review new FDA-approved drugs and new uses for existing drugs.

(H) Ensure the issuer's formulary drug list:

(*1*) Covers a range of drugs across a broad distribution of therapeutic categories and classes and recommended drug treatment regimens that treat all disease states, and does not discourage enrollment by any group of enrollees; and

(*2*) Provides appropriate access to drugs that are included in broadly accepted treatment guidelines and that are indicative of general best practices at the time.

(b) A health plan does not fail to provide EHB prescription drug benefits solely because it does not offer drugs approved by the Food and Drug Administration as a service described in § 156.280(d) of this subchapter.

(c) A health plan providing essential health benefits must have the following processes in place that allow an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber, as appropriate) to request and gain access to clinically appropriate drugs not otherwise covered by the health plan (a request for exception). In the event that an exception request is granted, the plan must treat the excepted drug(s) as an essential health benefit, including by counting any cost-sharing towards the plan's annual limitation on cost-sharing under § 156.130 and when calculating the plan's actuarial value under § 156.135.

(1) *Standard exception request.* For plans years beginning on or after January 1, 2016:

(i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request a standard review of a decision that a drug is not covered by the plan.

(ii) A health plan must make its determination on a standard exception and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following receipt of the request.

(iii) A health plan that grants a standard exception request must provide coverage of the non-formulary drug for the duration of the prescription, including refills.

(2) *Expedited exception request.* (i) A health plan must have a process for an enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request an expedited review based on exigent circumstances.

(ii) Exigent circumstances exist when an enrollee is suffering from a health condition that may seriously jeopardize the enrollee's life, health, or ability to regain maximum function or when an enrollee is undergoing a current course of treatment using a non-formulary drug.

(iii) A health plan must make its coverage determination on an expedited review request based on exigent circumstances and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 24 hours following receipt of the request.

(iv) A health plan that grants an exception based on exigent circumstances must provide coverage of the non-formulary drug for the duration of the exigency.

(3) *External exception request review.* For plans years beginning on or after January 1, 2016:

(i) If the health plan denies a request for a standard exception under paragraph (c)(1) of this section or for an expedited exception under paragraph (c)(2) of this section, the health plan must have a process for the enrollee, the enrollee's designee, or the enrollee's prescribing physician (or other prescriber) to request that the original exception request and subsequent denial of such request be reviewed by an independent review organization.

(ii) A health plan must make its determination on the external exception request and notify the enrollee or the enrollee's designee and the prescribing physician (or other prescriber, as appropriate) of its coverage determination no later than 72 hours following its receipt of the request, if the original request was a standard exception request under paragraph (c)(1) of this section, and no later than 24 hours following its receipt of the request, if the original request was an expedited exception request under paragraph (c)(2) of this section.

(iii) If a health plan grants an external exception review of a standard exception request, the health plan must provide coverage of the non-formulary drug for the duration of the prescription. If a health plan grants an external exception review of an expedited exception request, the health plan must provide coverage of the non-formulary drug for the duration of the exigency.

(4) *Application of coverage appeals laws.* (i) A State may determine that a health plan in the State satisfies the requirements of this paragraph (c) if the health plan has a process to allow an enrollee to request and gain access to clinically appropriate drugs not otherwise covered by the health plan that is compliant with the State's applicable coverage appeals laws and regulations that are at least as stringent as the requirements of this paragraph (c) and include:

(A) An internal review;

(B) An external review;

(C) The ability to expedite the reviews; and

(D) Timeframes that are the same or shorter than the timeframes under paragraphs (c)(1)(ii), (c)(2)(iii), and (c)(3)(ii) of this section.

(ii) [Reserved]

(d)(1) For plan years beginning on or after January 1, 2016, a health plan must publish an up-to-date, accurate, and complete list of all covered drugs on its formulary drug list, including any tiering structure that it has adopted and any restrictions on the manner in which a drug can be obtained, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS, the U.S. Office of Personnel Management, and the general public. A formulary drug list is easily accessible when:

(i) It can be viewed on the plan's public Web site through a clearly identifiable link or tab without requiring an individual to create or access an account or enter a policy number; and

(ii) If an issuer offers more than one plan, when an individual can easily discern which formulary drug list applies to which plan.

(2) A QHP in the Federally-facilitated Exchange must make available the information described in paragraph (d)(1) of this section on its Web site in an HHS-specified format and also submit this information to HHS, in a format and at times determined by HHS.

(e) For plan years beginning on or after January 1, 2017, a health plan providing essential health benefits must have the following access procedures:

(1) A health plan must allow enrollees to access prescription drug benefits at in-network retail pharmacies, unless:

(i) The drug is subject to restricted distribution by the U.S. Food and Drug Administration; or

(ii) The drug requires special handling, provider coordination, or patient education that cannot be provided by a retail pharmacy.

(2) A health plan may charge enrollees a different cost-sharing amount for obtaining a covered drug at a retail pharmacy, but all cost sharing will count towards the plan's annual limitation on cost sharing under § 156.130 and must be accounted for in the plan's actuarial value calculated under § 156.135.

§ 156.125 Prohibition on discrimination.

(a) An issuer does not provide EHB if its benefit design, or the implementation of its benefit design, discriminates based on an individual's age, expected length of life, present or predicted disability, degree

of medical dependency, quality of life, or other health conditions. Beginning on the earlier of January 1, 2023 (the start of the 2023 plan year) or upon renewal of any plan subject to this rule, a non-discriminatory benefit design that provides EHB is one that is clinically-based.

(b) An issuer providing EHB must comply with the requirements of § 156.200(e) of this subchapter; and

(c) Nothing in this section shall be construed to prevent an issuer from appropriately utilizing reasonable medical management techniques.

§ 156.130 Cost-sharing requirements.

(a) *Annual limitation on cost sharing.* (1) For a plan year beginning in the calendar year 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the annual dollar limit as described in section 223(c)(2)(A)(ii)(I) of the Internal Revenue Code of 1986 as amended, for self-only coverage that that [*sic*] is in effect for 2014; or

(ii) For other than self-only coverage—the annual dollar limit in section 223(c)(2)(A)(ii)(II) of the Internal Revenue Code of 1986 as amended, for non-self-only coverage that is in effect for 2014.

(2) For a plan year beginning in a calendar year after 2014, cost sharing may not exceed the following:

(i) For self-only coverage—the dollar limit for calendar year 2014 increased by an amount equal to the product of that amount and the premium adjustment percentage, as defined in paragraph (e) of this section.

(ii) For other than self-only coverage—twice the dollar limit for self-only coverage described in paragraph (a)(2)(i) of this section.

(b) [Reserved]

(c) *Special rule for network plans.* In the case of a plan using a network of providers, cost sharing paid by, or on behalf of, an enrollee for benefits provided outside of such network is not required to count toward the annual limitation on cost sharing (as defined in paragraph (a) of this section).

(d) *Increase annual dollar limits in multiples of 50.* For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in paragraph (a) of this section that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.

(e) *Premium adjustment percentage.* The premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013. HHS may publish the annual premium adjustment percentage in guidance in January of the calendar year preceding the benefit year for which the premium adjustment percentage is applicable, unless HHS proposes changes to the methodology, in which case, HHS will publish the annual premium adjustment percentage in an annual HHS notice of benefit and payment parameters or another appropriate rulemaking.

(f) *Coordination with preventive limits.* Nothing in this subpart is in derogation of the requirements of § 147.130 of this subchapter.

(g) *Coverage of emergency department services.* Emergency department services must be provided as follows:

(1) Without imposing any requirement under the plan for prior authorization of services or any limitation on coverage where the provider of services is out of network that is more restrictive than the requirements or limitations that apply to emergency department services received in network; and

(2) If such services are provided out-of- network, cost-sharing must be limited as provided in § 147.138(b)(3) of this subchapter.

(h) *Use of direct support offered by drug manufacturers.* Notwithstanding any other provision of this section, and to the extent consistent with State law, amounts paid toward reducing the cost sharing incurred by an enrollee using any form of direct support offered by drug manufacturers for specific prescription drugs may be, but are not required to be,

counted toward the annual limitation on cost sharing, as defined in paragraph (a) of this section.

§ 156.135 AV calculation for determining level of coverage.

(a) *Calculation of AV.* Subject to paragraphs (b) and (d) of this section, to calculate the AV of a health plan, the issuer must use the AV Calculator developed and made available by HHS for the given benefit year.

(b) *Exception to the use of the AV Calculator.* If a health plan's design is not compatible with the AV Calculator, the issuer must meet the following:

(1) Submit the actuarial certification from an actuary, who is a member of the American Academy of Actuaries, on the chosen methodology identified in paragraphs (b)(2) and (b)(3) of this section:

(2) Calculate the plan's AV by:

(i) Estimating a fit of its plan design into the parameters of the AV Calculator; and

(ii) Having an actuary, who is a member of the American Academy of Actuaries, certify that the plan design was fit appropriately in accordance with generally accepted actuarial principles and methodologies; or

(3) Use the AV Calculator to determine the AV for the plan provisions that fit within the calculator parameters and have an actuary, who is a member of the American Academy of Actuaries calculate and certify, in accordance with generally accepted actuarial principles and methodologies, appropriate adjustments to the AV identified by the calculator, for plan design features that deviate substantially from the parameters of the AV Calculator.

(4) The calculation methods described in paragraphs (b)(2) and (3) of this section may include only in-network cost-sharing, including multi-tier networks.

(c) *Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements.* For plans other than those in the individual market that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(i) Any current year HSA contributions are accounted for; and

(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

(d) *Use of state-specific standard population for the calculation of AV.* Beginning in 2015, if submitted by the State and approved by HHS, a state-specific data set will be used as the standard population to calculate AV in accordance with paragraph (a) of this section. The data set may be approved by HHS if it is submitted in accordance with paragraph (e) of this section and:

(1) Supports the calculation of AVs for the full range of health plans available in the market;

(2) Is derived from a non-elderly population and estimates those likely to be covered by private health plans on or after January 1, 2014;

(3) Is large enough that: (i) The demographic and spending patterns are stable over time; and (ii) Includes a substantial majority of the State's insured population, subject to the requirement in paragraph (d)(2) of this section;

(4) Is a statistically reliable and stable basis for area-specific calculations; and

(5) Contains claims data on health care services typically offered in the then-current market.

(e) *Submission of state-specific data.* AV will be calculated using the default standard population described in paragraph (f) of this section, unless a data set in a format specified by HHS that can support the use of the AV Calculator as described in

paragraph (a) of this section is submitted by a State and approved by HHS consistent with paragraph (d) of this section by a date specified by HHS.

(f) *Default standard population.* The default standard population for AV calculation will be developed and summary statistics, such as in continuance tables, will be provided by HHS in a format that supports the calculation of AV as described in paragraph (a) of this section.

(g) *Updates to the AV Calculator.* HHS will update the AV Calculator annually for material changes that may include costs, plan designs, the standard population, developments in the function and operation of the AV Calculator and other actuarially relevant factors.

§ 156.140 Levels of coverage.

(a) *General requirement for levels of coverage.* AV, calculated as described in § 156.135 of this subpart, and within a de minimis variation as defined in paragraph (c) of this section, determines whether a health plan offers a bronze, silver, gold, or platinum level of coverage.

(b) *The levels of coverage* are:

(1) *A bronze health plan* is a health plan that has an AV of 60 percent.

(2) *A silver health plan* is a health plan that has an AV of 70 percent.

(3) *A gold health plan* is a health plan that has an AV of 80 percent.

(4) *A platinum health plan* is a health plan that has as an AV of 90 percent.

(c) *De minimis variation.* (1) For plan years beginning on or after January 1, 2018 through December 31, 2022, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is –4 percentage points and +2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such plan is –4 percentage points and +5 percentage points.

(2) For plan years beginning on or after January 1, 2023, the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan is –2 percentage points and +2 percentage points, except if a health plan under paragraph (b)(1) of this section (a bronze health plan) either covers and pays for at least one major service, other than preventive services, before the deductible or meets the requirements to be a high deductible health plan within the meaning of section 223(c)(2) of the Internal Revenue Code, in which case the allowable variation in AV for such plan is –2 percentage points and +5 percentage points.

§ 156.145 Determination of minimum value.

(a) *Acceptable methods for determining MV.* An employer-sponsored plan provides minimum value (MV) only if the percentage of the total allowed costs of benefits provided under the plan is greater than or equal to 60 percent, and the benefits under the plan include substantial coverage of inpatient hospital services and physician services. An employer-sponsored plan may use one of the following methods to determine whether the percentage of the total allowed costs of benefits provided under the plan is not less than 60 percent.

(1) The MV Calculator to be made available by HHS and the Internal Revenue Service. The result derived from the calculator may be modified under the rules in paragraph (b) of this section.

(2) Any safe harbor established by HHS and the Internal Revenue Service.

(3) A group health plan may seek certification by an actuary to determine MV if the plan contains non-standard features that are not suitable for either of the methods described in paragraphs (a)(1) or (2) of this section. The determination of MV must be made by a member of the American Academy of Actuaries, based on an analysis performed in accordance with generally accepted actuarial principles and methodologies.

(4) Any plan in the small group market that meets any of the levels of coverage, as described in

§ 156.140 of this subpart, satisfies minimum value.

(b) *Benefits that may be counted towards the determination of MV.* (1) In the event that a group health plan uses the MV Calculator and offers an EHB outside of the parameters of the MV Calculator, the plan may seek an actuary, who is a member of the American Academy of Actuaries, to determine the value of that benefit and adjust the result derived from the MV Calculator to reflect that value.

(2) For the purposes of applying the options described in paragraph (a) of this section in determining MV, a group health plan will be permitted to take into account all benefits provided by the plan that are included in any one of the EHB-benchmarks.

(c) *Standard population.* The standard population for MV determinations described in paragraph (a) of this section is the standard population developed by HHS for such use and described through summary statistics issued by HHS. The standard population for MV must reflect the population covered by self-insured group health plans.

(d) *Employer contributions to health savings accounts and amounts made available under certain health reimbursement arrangements.* For employer-sponsored self-insured group health plans and insured group health plans that at the time of purchase are offered in conjunction with an HSA or with integrated HRAs that may be used only for cost-sharing, annual employer contributions to HSAs and amounts newly made available under such HRAs for the current year are:

(1) Counted towards the total anticipated medical spending of the standard population that is paid by the health plan; and

(2) Adjusted to reflect the expected spending for health care costs in a benefit year so that:

(i) Any current year HSA contributions are accounted for; and

(ii) The amounts newly made available under such integrated HRAs for the current year are accounted for.

§ 156.150 Application to stand-alone dental plans inside the Exchange.

(a) *Annual limitation on cost-sharing.* For a stand-alone dental plan covering the pediatric dental EHB under § 155.1065 of this subchapter in any Exchange, cost sharing may not exceed $350 for one covered child and $700 for two or more covered children.

(1) For plan years beginning after 2017, for one covered child—the dollar limit applicable to a stand-alone dental plan for one covered child specified in this paragraph (a) increased by the percent increase of the consumer price index for dental services for the year 2 years prior to the applicable plan year over the consumer price index for dental services for 2016.

(2) For plan years after 2017, for two or more covered children—twice the dollar limit for one child described in paragraph (a)(1) of this section.

(b) *Calculation of AV.* A stand-alone dental plan:

(1) May not use the AV calculator in § 156.135; and

(2) Must have the plan's actuarial value of coverage for pediatric dental essential health benefits certified by a member of the American Academy of Actuaries using generally accepted actuarial principles and reported to the Exchange.

(c) *Consumer price index for dental services defined.* The consumer price index for dental services is a subcomponent of the U.S. Department of Labor's Bureau of Labor Statistics Consumer Price Index specific to dental services.

(d) *Increments of cost sharing increases.* Any increase in the annual dollar limits described in paragraph (a)(1) of this section that does not result in a multiple of 25 dollars will be rounded down, to the next lowest multiple of 25 dollars.

§ 156.155 Enrollment in catastrophic plans.

(a) *General rule.* A health plan is a catastrophic plan if it meets the following conditions:

(1) Meets all applicable requirements for health insurance coverage in the individual market (including but not limited to those requirements

described in parts 147 and 148 of this subchapter), and is offered only in the individual market.

(2) Does not provide a bronze, silver, gold, or platinum level of coverage described in section 1302(d) of the Affordable Care Act.

(3) Provides coverage of the essential health benefits under section 1302(b) of the Affordable Care Act, except that the plan provides no benefits for any plan year (except as provided in paragraphs (a)(4), (b), and (c) of this section) until the annual limitation on cost sharing in section 1302(c)(1) of the Affordable Care Act is reached.

(4) Provides coverage for at least three primary care visits per year before reaching the deductible.

(5) Covers only individuals who meet either of the following conditions:

(i) Have not attained the age of 30 prior to the first day of the plan or policy year.

(ii) Have received a certificate of exemption for the reasons identified in section 1302(e)(2)(B)(i) or (ii) of the Affordable Care Act.

(b) *Coverage of preventive health services.* A catastrophic plan may not impose any cost-sharing requirements (such as a copayment, coinsurance, or deductible) for preventive services, in accordance with section 2713 of the Public Health Service Act.

(c) *Coverage to prevent surprise medical bills.* A catastrophic plan must provide benefits as required under sections 2799A–1 and 2799A–2 of the Public Health Service Act and their implementing regulations in §§ 149.110, 149.120, and 149.130 or any applicable State law providing similar protections to individuals, and will not violate paragraph (a)(3) of this section solely because of the provision of such benefits before the annual limitation on cost sharing is reached.

(d) *Application for family coverage.* For other than self-only coverage, each individual enrolled must meet the requirements of paragraph (a)(5) of this section.

SUBPART C—QUALIFIED HEALTH PLAN MINIMUM CERTIFICATION STANDARDS

§ 156.200 QHP issuer participation standards.

(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) *QHP issuer requirement.* A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 of this subchapter and, in the small group market, §§ 155.705 and 155.706 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20, except that individual market silver QHPs must have an AV of 70 percent, with a *de minimis* allowable AV variation of –0 percentage points and +2 percentage points;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards under 45 CFR part 153.

(c) *Offering requirements.* A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in § 156.140 throughout each service area in which it offers coverage through the Exchange; and,

(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.

(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, or sex.

(f) *Broker compensation in a Federally-facilitated Exchange.* A QHP issuer must pay the same broker compensation for QHPs offered through a Federally-facilitated Exchange that the QHP issuer pays for similar health plans offered in the State outside a Federally-facilitated Exchange.

(g) *Certification standard specific to a Federally-facilitated Exchange for plan years beginning before January 1, 2018.* A Federally-facilitated Exchange may certify a QHP in the individual market of a Federally-facilitated Exchange only if the QHP issuer meets one of the conditions below:

(1) The QHP issuer also offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage as described in section 1302(d) of the Affordable Care Act;

(2) The QHP issuer does not offer small group market products in that State, but another issuer in the same issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under § 158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.

(h) *Operational requirements.* As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in subparts D, E, H, K, L, and M of this part.

§ 156.201 Standardized plan options.

A qualified health plan (QHP) issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform, other than an issuer that is already required to offer standardized plan options under State action taking place on or before January 1, 2020, must:

(a) For the plan year 2023, offer in the individual market at least one standardized QHP option, defined at § 155.20 of this subchapter, at every product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, at every metal level, and throughout every service area that it also offers non-standardized QHP options, including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a); and

(b) For plan year 2024 and subsequent plan years, offer in the individual market at least one standardized QHP option, defined at § 155.20 of this subchapter, at every product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, at every metal level except the non-expanded bronze metal level, and throughout every service area that it also offers non-standardized QHP options, including, for silver plans, for the income-based cost-sharing reduction plan variations, as provided for at § 156.420(a).

§ 156.202 Non-standardized plan option limits.

A QHP issuer in a Federally-facilitated Exchange or a State-based Exchange on the Federal platform:

(a) For plan year 2024, is limited to offering four non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

(b) For plan year 2025 and subsequent plan years, is limited to offering two non-standardized plan options per product network type, as the term is described in the definition of "product" at § 144.103 of this subchapter, metal level (excluding catastrophic plans), and inclusion of dental and/or vision benefit coverage (as defined in paragraph (c) of this section), in any service area.

(c) For purposes of paragraphs (a) and (b) of this section, the inclusion of dental and/or vision benefit coverage is defined as coverage of any or all of the following:

(1) Adult dental benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template:

(i) Routine Dental Services (Adult);

(ii) Basic Dental Care—Adult; or

(iii) Major Dental Care—Adult.

(2) Pediatric dental benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template:

(i) Dental Check-Up for Children;

(ii) Basic Dental Care—Child; or

(iii) Major Dental Care—Child.

(3) Adult vision benefit coverage as defined by the following in the "Benefits" column in the Plans and Benefits Template: Routine Eye Exam (Adult).

§ 156.210 QHP rate and benefit information.

(a) *General rate requirement.* A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

(b) *Rate and benefit submission.* A QHP issuer must submit rate and benefit information to the Exchange.

(c) *Rate justification.* A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.

(d) *Rate requirements* for *stand-alone dental plans.* For benefit and plan years beginning on or after January 1, 2024:

(1) *Age on effective date.* The premium rate charged by an issuer of stand-alone dental plans may vary with respect to the particular plan or coverage involved by determining the enrollee's age. Any age calculation for rating and eligibility purposes must be based on the age as of the time of policy issuance or renewal.

(2) *Guaranteed rates.* An issuer of stand-alone dental plans must set guaranteed rates.

§ 156.215 Advance payments of the premium tax credit and cost-sharing reduction standards.

(a) *Standards relative to advance payments of the premium tax credit and cost-sharing reductions.* In order for a health plan to be certified as a QHP initially and to maintain certification to be offered in the individual market on the Exchange, the issuer must meet the requirements related to the administration of cost-sharing reductions and advance payments of the premium tax credit set forth in subpart E of this part.

(b) [Reserved]

§ 156.220 Transparency in coverage.

(a) *Required information.* A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:

(1) Claims payment policies and practices;

(2) Periodic financial disclosures;

(3) Data on enrollment;

(4) Data on disenrollment;

(5) Data on the number of claims that are denied;

(6) Data on rating practices;

(7) Information on cost-sharing and payments with respect to any out-of-network coverage; and

(8) Information on enrollee rights under title I of the Affordable Care Act.

(b) *Reporting requirement.* A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) *Use of plain language.* A QHP issuer must make sure that the information submitted under paragraph (b) is provided in plain language as defined under § 155.20 of this subtitle.

(d) *Enrollee cost sharing transparency.* A QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.

§ 156.221 Access to and exchange of health data and plan information [Interoperability Rule].

(a) *Application Programming Interface to support enrollees.* Subject to paragraph (h) of this section, a QHP issuer on a Federally-Facilitated Exchange must implement and maintain a standards-based Application Programming Interface (API) that permits third-party applications to retrieve, with the approval and at the direction of a current individual enrollee or the enrollee's personal representative, data specified in paragraph (b) of this section through the use of common technologies and without special effort from the enrollee.

(b) *Accessible content.* (1) A QHP issuer on a Federally-facilitate Exchange must make the following information accessible to its current enrollees or the enrollee's personal representative through the API described in paragraph (a) of this section:

(i) Data concerning adjudicated claims, including claims data for payment decisions that may be appealed, were appealed, or are in the process of appeal, and provider remittances and enrollee cost-sharing pertaining to such claims, no later than one (1) business day after a claim is processed;

(ii) Encounter data from capitated providers, no later than one (1) business day after data concerning the encounter is received by the QHP issuer; and

(iii) Clinical data, including laboratory results, if the QHP issuer maintains any such data, no later than one (1) business day after data is received by the issuer.

(2) [Reserved]

(c) *Technical requirements.* A QHP issuer on a Federally-facilitated Exchange implementing an API under paragraph (a) of this section:

(1) Must implement, maintain, and use API technology conformant with 45 CFR 170.215;

(2) Must conduct routine testing and monitoring, and update as appropriate, to ensure the API functions properly, including assessments to verify the API is fully and successfully implementing privacy and security features such as, but not limited to, those required to comply with HIPAA privacy and security requirements in parts 160 and 164, 42 CFR parts 2 and 3, and other applicable law protecting privacy and security of individually identifiable data;

(3) Must comply with the content and vocabulary standard requirements in paragraphs (c)(3)(i) and (ii) of this section, as applicable, to the data type or data element, unless alternate standards are required by other applicable law:

(i) Content and vocabulary standards at 45 CFR 170.213 where such are applicable to the data type or element, as appropriate; and

(ii) Content and vocabulary standards at part 162 of this subchapter and 42 CFR 423.160 where required by law, or where such standards are applicable to the data type or element, as appropriate.

(4) May use an updated version of any standard or all standards required under paragraphs (c)(1) or (3) of this section, where:

(i) Use of the updated version of the standard is required by other applicable law, or

(ii) Use of the updated version of the standard is not prohibited under other applicable law, provided that:

(A) For content and vocabulary standards other than those at 45 CFR 170.213, the Secretary has not prohibited use of the updated version of a standard for purposes of this section or part 170 of this subchapter;

(B) For standards at 45 CFR 170.213 and 45 CFR 170.215, the National Coordinator has approved the updated version for use in the ONC Health IT Certification Program; and

(C) Use of the updated version of a standard does not disrupt an end user's ability to access the data described in paragraph (b) of this section through the API described in paragraph (a) of this section.

(d) *Documentation requirements for APIs.* For each API implemented in accordance with paragraph (a) of this section, a QHP issuer on a Federally-Facilitated Exchange must make publicly accessible, by posting directly on its website and/or via publicly accessible hyperlink(s), complete accompanying documentation that contains, at a minimum the information listed in this paragraph. For the purposes of this section, ''publicly accessible'' means that any person using commonly available technology to browse the internet could access the information without any preconditions or additional steps, such as a fee for access to the documentation; a requirement to receive a copy of the material via email; a requirement to register or create an account to receive the documentation; or a requirement to read promotional material or agree to receive future communications from the organization making the documentation available;

(1) API syntax, function names, required and optional parameters supported and their data types, return variables and their types/structures, exceptions and exception handling methods and their returns;

(2) The software components and configurations an application must use in order to successfully interact with the API and process its response(s); and

(3) All applicable technical requirements and attributes necessary for an application to be registered with any authorization server(s) deployed in conjunction with the API.

(e) *Denial or discontinuation of access to the API.* A QHP issuer on a Federally-Facilitated Exchange may deny or discontinue any third party application's connection to the API required under paragraph (a) of this section if the QHP issuer:

(1) Reasonably determines, consistent with its security risk analysis under 45 CFR part 164 subpart C, that allowing an application to connect or remain connected to the API would present an unacceptable level of risk to the security of personally identifiable information, including protected health information, on the QHP issuer's systems; and

(2) Makes this determination using objective, verifiable criteria that are applied fairly and consistently across all applications and developers through which enrollees seek to access their electronic health information as defined at § 171.102 of this subchapter, including but not limited to criteria that may rely on automated monitoring and risk mitigation tools.

(f) *Coordination among payers.* (1) A QHP issuer on a Federally-facilitated Exchange must maintain a process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Such

information received by a QHP issuer on a Federally-facilitated Exchange must be incorporated into the QHP issuer's records about the current enrollee. With the approval and at the direction of a current or former enrollee or the enrollee's personal representative, a QHP issuer on a Federally-facilitated Exchange must:

(i) Receive all such data for a current enrollee from any other payer that has provided coverage to the enrollee within the preceding 5 years;

(ii) At any time the enrollee is currently enrolled in the plan and up to 5 years after disenrollment, send all such data to any other payer that currently covers the enrollee or a payer the enrollee or the enrollee's personal representative specifically requests receive the data; and

(iii) Send data received from another payer under this paragraph (f) in the electronic form and format it was received.

(2) [Reserved]

(g) *Enrollee resources regarding privacy and security.* A QHP issuer on a Federally-facilitated Exchange must provide in an easily accessible location on its public website and through other appropriate mechanisms through which it ordinarily communicates with current and former enrollees seeking to access their health information held by the QHP issuer, educational resources in non-technical, simple and easy-to-understand language explaining at a minimum:

(1) General information on steps the individual may consider taking to help protect the privacy and security of their health information, including factors to consider in selecting an application including secondary uses of data, and the importance of understanding the security and privacy practices of any application to which they will entrust their health information; and

(2) An overview of which types of organizations or individuals are and are not likely to be HIPAA covered entities, the oversight responsibilities of the Office for Civil Rights (OCR) and the Federal Trade Commission (FTC), and how to submit a complaint to:

(i) The HHS Office for Civil Rights (OCR); and

(ii) The Federal Trade Commission (FTC).

(h) *Exception.* (1) If a plan applying for QHP certification to be offered through a Federally-facilitated Exchange believes it cannot satisfy the requirements in paragraphs (a) through (g) of this section, the issuer must include as part of its QHP application a narrative justification describing the reasons why the plan cannot reasonably satisfy the requirements for the applicable plan year, the impact of noncompliance upon enrollees, the current or proposed means of providing health information to enrollees, and solutions and a timeline to achieve compliance with the requirements of this section.

(2) The Federally-facilitated Exchange may grant an exception to the requirements in paragraphs (a) through (g) of this section if the Exchange determines that making such health plan available through such Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates.

(i) *Applicability.* A QHP issuer on an individual market Federally-facilitated Exchange, not including QHP issuers offering only stand-alone dental plans, must comply with the requirements in paragraphs (a) through (e) and (g) of this section beginning with plan years beginning on or after January 1, 2021, and with the requirements in paragraph (f) of this section beginning with plan years beginning on or after January 1, 2022 with regard to data:

(1) With a date of service on or after January 1, 2016; and

(2) That are maintained by the QHP issuer for enrollees in QHPs.

§ 156.225 Marketing and benefit design of QHPs.

A QHP issuer and its officials, employees, agents and representatives must—

(a) *State law applies.* Comply with any applicable State laws and regulations regarding marketing by health insurance issuers;

(b) *Non-discrimination.* Not employ marketing practices or benefit designs that will have the effect

of discouraging the enrollment of individuals with significant health needs in QHPs; and

(c) *Plan marketing names.* Offer plans and plan variations with marketing names that include correct information, without omission of material fact, and do not include content that is misleading.

§ 156.230 Network adequacy standards.

(a) *General requirement.* (1) Each QHP issuer must use a provider network and ensure that the provider network consisting of in-network providers, as available to all enrollees, meets the following standards:

(i) Includes essential community providers in accordance with § 156.235;

(ii) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance use disorder services, to ensure that all services will be accessible without unreasonable delay; and

(iii) Is consistent with the rules for network plans of section 2702(c) of the PHS Act.

(2)(i) *Standards.* A QHP issuer on a Federally-facilitated Exchange must comply with the requirement in paragraph (a)(1)(ii) of this section by:

(A) For plan years beginning on or after January 1, 2023, meeting time and distance standards established by the Federally-facilitated Exchange. Such time and distance standards will be developed for consistency with industry standards and published in guidance. Quantitative reviews of compliance with time and distance standards will be conducted using issuer-submitted data; and

(B) For plan years beginning on or after January 1, 2025, meeting appointment wait time standards established by the Federally-facilitated Exchange. Such appointment wait time standards will be developed for consistency with industry standards and published in guidance.

(ii) *Written justification.* If a plan applying for QHP certification to be offered through a Federally-facilitated Exchanges does not satisfy the network adequacy standards described in paragraphs (a)(2)(i)(A) and (B) of this section, the issuer must include it as part of its QHP application a justification describing how the plan's provider network provides an adequate level of service for enrollees and how the plan's provider network will be strengthened and brought closer to compliance with the network adequacy standards prior to the start of the plan year. The issuer must provide information as requested by the FFE to support this justification.

(3) The Federally-facilitated Exchange may grant an exception to the requirements in paragraphs (a)(2)(i)(A) and (B) of this section if the Exchange determines that making such health plan available through such Exchange is in the interests of qualified individuals in the State or States in which such Exchange operates.

(4) A limited exception to the requirement described under paragraph (a)(1) of this section that each QHP issuer use a provider network is available to stand-alone dental plans issuers that sell plans in areas where it is prohibitively difficult for the issuer to establish a network of dental providers; this exception is not available to medical QHP issuers. Under this exception, an area is considered "prohibitively difficult" for the standalone dental plan issuer to establish a network of dental providers based on attestations from State departments of insurance in States with at least 80 percent of counties classified as Counties with Extreme Access Considerations (CEAC) that at least one of the following factors exists in the area of concern: a significant shortage of dental providers, a significant number of dental providers unwilling to contract with Exchange issuers, or significant geographic limitations impacting consumer access to dental providers.

(b) *Access to provider directory.* (1) A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from HHS and to potential enrollees in hard copy upon request. In the provider directory, a

QHP issuer must identify providers that are not accepting new patients.

(2) For plan years beginning on or after January 1, 2016, a QHP issuer must publish an up-to-date, accurate, and complete provider directory, including information on which providers are accepting new patients, the provider's location, contact information, specialty, medical group, and any institutional affiliations, in a manner that is easily accessible to plan enrollees, prospective enrollees, the State, the Exchange, HHS and OPM. A provider directory is easily accessible when—

(i) The general public is able to view all of the current providers for a plan in the provider directory on the issuer's public Web site through a clearly identifiable link or tab and without creating or accessing an account or entering a policy number; and

(ii) If a health plan issuer maintains multiple provider networks, the general public is able to easily discern which providers participate in which plans and which provider networks.

(c) *Increasing consumer transparency.* A QHP issuer in a Federally-facilitated Exchange must make available the information described in paragraph (b) of this section on its Web site in an HHS specified format and also submit this information to HHS, in a format and manner and at times determined by HHS.

(d) *Provider transitions.* A QHP issuer in a Federally-facilitated Exchange must—

(1) Make a good faith effort to provide written notice of discontinuation of a provider 30 days prior to the effective date of the change or otherwise as soon as practicable, to enrollees who are patients seen on a regular basis by the provider or who receive primary care from the provider whose contract is being discontinued, irrespective of whether the contract is being discontinued due to a termination for cause or without cause, or due to a nonrenewal;

(2) In cases where a provider is terminated without cause, allow an enrollee in an active course of treatment to continue treatment until the treatment is complete or for 90 days, whichever is shorter, at in-network cost-sharing rates.

(i) For the purposes of paragraph (d)(2) of this section, active course of treatment means:

(A) An ongoing course of treatment for a life-threatening condition, defined as a disease or condition for which likelihood of death is probable unless the course of the disease or condition is interrupted;

(B) An ongoing course of treatment for a serious acute condition, defined as a disease or condition requiring complex ongoing care which the covered person is currently receiving, such as chemotherapy, radiation therapy, or post-operative visits;

(C) The second or third trimester of pregnancy, through the postpartum period; or

(D) An ongoing course of treatment for a health condition for which a treating physician or health care provider attests that discontinuing care by that physician or health care provider would worsen the condition or interfere with anticipated outcomes.

(ii) Any QHP issuer decision made for a request for continuity of care under paragraph (d)(2) of this section must be subject to the health benefit plan's internal and external grievance and appeal processes in accordance with applicable State or Federal law or regulations.

(e) *Out-of-network cost sharing.* Beginning for the 2018 and later benefit years, for a network to be deemed adequate, each QHP must:

(1) Notwithstanding § 156.130(c), count the cost sharing paid by an enrollee for an essential health benefit provided by an out-of-network ancillary provider in an in-network setting towards the enrollee's annual limitation on cost sharing; or

(2) Provide a written notice to the enrollee by the longer of when the issuer would typically respond to a prior authorization request timely submitted, or 48 hours before the provision of the benefit, that additional costs may be incurred for an essential health benefit provided by an out-of-network ancillary provider in an in-network

setting, including balance billing charges, unless such costs are prohibited under State law, and that any additional charges may not count toward the in-network annual limitation on cost sharing.

(f) [Reserved]

§ 156.235 Essential community providers.

(a) *General ECP standard.* (1) A QHP issuer must include in its provider network a sufficient number and geographic distribution of essential community providers (ECPs), where available, to ensure reasonable and timely access to a broad range of such providers for low-income individuals or individuals residing in Health Professional Shortage Areas within the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A plan applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of ECPs if it demonstrates in its QHP application that—

(i) The QHP issuer's provider network includes as participating providers at least a minimum percentage, as specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For plans with two network tiers (for example, participating providers and preferred providers), such as many preferred provider organizations (PPOs), where cost-sharing is lower for preferred providers, only preferred providers will be counted towards ECP standards; and

(ii) The issuer of the plan offers contracts to—

(A) All available Indian health care providers in the service area, applying the special terms and conditions required by Federal law and regulations as referenced in the recommended model QHP addendum for Indian health care providers developed by HHS; and

(B) At least one ECP in each of the eight (8) ECP categories in each county in the service area, where an ECP in that category is available and provides medical or dental services that are covered by the issuer plan type. The ECP categories are: Federally Qualified Health Centers, Ryan White Program Providers, Family Planning Providers, Indian Health Care Providers, Inpatient Hospitals, Mental Health Facilities, Substance Use Disorder Treatment Centers, and Other ECP Providers. The Other ECP Providers category includes the following types of providers: Rural Health Clinics, Black Lung Clinics, Hemophilia Treatment Centers, Sexually Transmitted Disease Clinics, Tuberculosis Clinics, and Rural Emergency Hospitals.

(3) If a plan applying for QHP certification to be offered through a Federally-facilitated Exchange does not satisfy the ECP standard described in paragraph (a)(2) of this section, the issuer must include as part of its QHP application a narrative justification describing how the plan's provider network provides an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

(4) Nothing in paragraphs (a)(1) through (3) of this section requires any QHP to provide coverage for any specific medical procedure.

(5) A plan that provides a majority of covered professional services through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(b) *Alternate ECP standard.* (1) A plan described in paragraph (a)(5) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities, to ensure reasonable and timely access for low-income individuals or individuals residing in Health Professional Shortage Areas within the plan's service area, in accordance with the Exchange's network adequacy standards.

(2) A plan described in paragraph (a)(5) of this section applying for QHP certification to be offered through a Federally-facilitated Exchange has a sufficient number and geographic distribution of employed or contracted providers if it demonstrates in its QHP application that—

(i) The number of its providers that are located in Health Professional Shortage Areas or five-digit zip codes in which 30 percent or more of the population falls below 200 percent of the Federal poverty level satisfies a minimum percentage, specified by HHS, of available ECPs in each plan's service area collectively across all ECP categories defined under paragraph (a)(2)(ii)(B) of this section, and at least a minimum percentage of available ECPs in each plan's service area within certain individual ECP categories, as specified by HHS. Multiple providers at a single location will count as a single ECP toward both the available ECPs in the plan's service area and the issuer's satisfaction of the ECP participation standard. For plans that use tiered networks, to count toward the issuer's satisfaction of the ECP standards, providers must be contracted within the network tier that results in the lowest cost-sharing obligation. For plans with two network tiers (for example, participating providers and preferred providers), such as many PPOs, where cost sharing is lower for preferred providers, only preferred providers would be counted towards ECP standards; and

(ii) The issuer's integrated delivery system provides all of the categories of services provided by entities in each of the ECP categories in each county in the plan's service area as outlined in the general ECP standard, or otherwise offers a contract to at least one ECP outside of the issuer's integrated delivery system per ECP category in each county in the plan's service area that can provide those services to low-income, medically underserved individuals.

(3) If a plan does not satisfy the alternate ECP standard described in paragraph (b)(2) of this section, the issuer must include as part of its QHP application a narrative justification describing how the plan's provider networks provide an adequate level of service for low-income enrollees or individuals residing in Health Professional Shortage Areas within the plan's service area and how the plan's provider network will be strengthened toward satisfaction of the ECP standard prior to the start of the benefit year.

(c) *Definition.* An essential community provider is a provider that serves predominantly low-income, medically underserved individuals, including a health care provider defined in section 340B(a)(4) of the PHS Act; or described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111–8; or a State-owned family planning service site, or governmental family planning service site, or not-for-profit family planning service site that does not receive Federal funding under special programs, including under Title X of the PHS Act, or an Indian health care provider, unless any of the above providers has lost its status under either of these sections, 340(B) of the PHS Act or 1927 of the Act as a result of violating Federal law.

(d) *Payment rates.* Nothing in paragraph (a) of this section may be construed to require a QHP issuer to contract with an ECP if such provider refuses to accept the same rates and contract provisions included in contracts accepted by similarly situated providers.

(e) *Payment of Federally qualified health centers.* If an item or service covered by a QHP is provided by a Federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the Federally qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the Act for such item or service. Nothing in this paragraph (e) precludes a QHP issuer and Federally-qualified health center from agreeing upon payment rates other than those that would have been

paid to the center under section 1902(bb) of the Act, as long as that rate is at least equal to the generally applicable payment rate of the issuer described in paragraph (d) of this section.

§ 156.245 Treatment of direct primary care medical homes.

A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.

§ 156.250 Meaningful access to qualified health plan information.

A QHP issuer must provide all information that is critical for obtaining health insurance coverage or access to health care services through the QHP, including applications, forms, and notices, to qualified individuals, applicants, qualified employers, qualified employees, and enrollees in accordance with the standards described in § 155.205(c) of this subchapter. Information is deemed to be critical for obtaining health insurance coverage or access to health care services if the issuer is required by law or regulation to provide the document to a qualified individual, applicant, qualified employer, qualified employee, or enrollee.

§ 156.255 Rating variations.

(a) *Rating areas.* A QHP issuer, including an issuer of a multi-State plan, may vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS Act.

(b) *Same premium rates.* A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.

§ 156.260 Enrollment periods for qualified individuals.

(a) *Individual market requirement.* A QHP issuer must:

(1) Enroll a qualified individual during the initial and annual open enrollment periods described in § 155.410(b) and (e) of this subchapter, and abide by the effective dates of coverage established by the Exchange in accordance with § 155.410(c) and (f) of this subchapter; and

(2) Make available, at a minimum, special enrollment periods described in § 155.420(d) of this subchapter, for QHPs and abide by the effective dates of coverage established by the Exchange in accordance with § 155.420(b) of this subchapter.

(b) *Notification of effective date.* A QHP issuer must notify a qualified individual of his or her effective date of coverage.

§ 156.265 Enrollment process for qualified individuals.

(a) *General requirement.* A QHP issuer must process enrollment in accordance with this section.

(b) *Enrollment through the Exchange for the individual market.* (1) A QHP issuer must enroll a qualified individual only if the Exchange—

(i) Notifies the QHP issuer that the individual is a qualified individual; and

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter.

(2) If an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange, the QHP issuer must either—

(i) Direct the individual to file an application with the Exchange in accordance with § 155.310, or

(ii) Ensure the applicant's completion of an eligibility verification and enrollment application through the Exchange Internet Web site as described in § 155.405, or ensure that the eligibility application information is submitted for an eligibility determination through the Exchange-approved Web service subject to meeting the requirements in paragraph (b)(3) through (5) of this section;

(3) When an Internet Web site of an issuer is used to complete the Exchange eligibility application

outlined in this section, at a minimum, the Internet Web site must:

(i) Use exactly the same eligibility application language as appears in the FFE Single Streamlined Application required in § 155.405 of this subchapter, unless HHS approves a deviation;

(ii) Ensure that all necessary information for the consumer's applicable eligibility circumstances are submitted through the Exchange-approved Web service;

(iii) Ensure that the process used for consumers to complete the eligibility application complies with all applicable Exchange standards, including §§ 155.230 and 155.260(b) of this subchapter; and

(iv) Differentially display all standardized options in accordance with the requirements under § 155.205(b)(1) in a manner consistent with that adopted by HHS for display on the Federally-facilitated Exchange Web site, unless HHS approves a deviation.

(4) An issuer must obtain HHS approval that the requirements of this section have been met prior to completing an applicant's eligibility application through the issuer's Internet Web site.

(5) HHS or its designee may periodically monitor and audit an agent, broker, or issuer to assess its compliance with the applicable requirements of this section.

(c) *Acceptance of enrollment information.* A QHP issuer must accept enrollment information consistent with the privacy and security requirements established by the Exchange in accordance with § 155.260 and in an electronic format that is consistent with § 155.270.

(d) *Premium payment.* A QHP issuer must follow the premium payment process established by the Exchange in accordance with § 155.240 of this subchapter and the payment rules established in § 155.400(e) of this subchapter.

(e) *Enrollment information package.* A QHP issuer must provide new enrollees an enrollment information package that is compliant with accessibility and readability standards established in § 155.230(b).

(f) *Enrollment reconciliation.* A QHP issuer must reconcile enrollment files with the Exchange in a format specified by the Exchange (or, for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform) and resolve assigned updates no less than once a month in accordance with § 155.400(d) of this subchapter, using the most recent enrollment information that is available and that has been verified to the best of the issuer's knowledge or belief.

(g) *Timely updates to enrollment records.* A QHP issuer offering plans through an Exchange must, in a format specified by the Exchange (or, for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform), either:

(1) Verify to the Exchange (or, for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform) that the information in the enrollment reconciliation file received from the Exchange (or, for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform) accurately reflects its enrollment data for the applicable benefit year in its next enrollment reconciliation file submission to the Exchange (or, for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform), and update its internal enrollment records accordingly; or

(2) Describe to the Exchange (or for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform) within one reconciliation cycle any discrepancy it identifies in the enrollment reconciliation files it received from the Exchange (or for QHP issuers in State Exchanges on the Federal Platform, the Federal Platform).

§ 156.270 Termination of coverage or enrollment for qualified individuals.

(a) *General requirement.* A QHP issuer may only terminate enrollment in a QHP through the Exchange as permitted by the Exchange in accordance with § 155.430(b) of this subchapter. (See also § 147.106 of this subchapter for termination of coverage.)

(b) *Termination of coverage or enrollment notice requirement.* If a QHP issuer terminates an enrollee's

coverage or enrollment in a QHP through the Exchange in accordance with § 155.430(b) of this subchapter, the QHP issuer must, promptly and without undue delay:

(1) Provide the enrollee with a notice of termination that includes the termination effective date and reason for termination.

(2) [Reserved]

(c) *Termination of coverage or enrollment due to non-payment of premium.* A QHP issuer must establish a standard policy for the termination of enrollment of enrollees through the Exchange due to non-payment of premium as permitted by the Exchange in § 155.430(b)(2)(ii) of this subchapter. This policy for the termination of enrollment:

(1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and

(2) Must be applied uniformly to enrollees in similar circumstances.

(d) *Grace period for recipients of advance payments of the premium tax credit.* A QHP issuer must provide a grace period of 3 consecutive months for an enrollee, who when failing to timely pay premiums, is receiving advance payments of the premium tax credit. During the grace period, the QHP issuer must:

(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

(2) Notify HHS of such non-payment; and,

(3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

(e) *Advance payments of the premium tax credit.* For the 3-month grace period described in paragraph (d) of this section, a QHP issuer must:

(1) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the Department of the Treasury.

(2) Return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as described in paragraph (g) of this section.

(f) *Notice of non-payment of premiums.* If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency. Issuers offering QHPs in Exchanges on the Federal platform must provide such notices promptly and without undue delay, within 10 business days of the date the issuer should have discovered the delinquency.

(g) *Exhaustion of grace period.* If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, subject to a premium payment threshold implemented under § 155.400(g) of this subchapter, if applicable, the QHP issuer must terminate the enrollee's enrollment through the Exchange on the effective date described in § 155.430(d)(4) of this subchapter, provided that the QHP issuer meets the notice requirement specified in paragraph (b) of this section.

(h) *Records of termination of coverage.* QHP issuers must maintain records in accordance with Exchange standards established in accordance with § 155.430(c) of this subchapter.

(i) *Effective date of termination of coverage or enrollment.* QHP issuers must abide by the termination of coverage or enrollment effective dates described in § 155.430(d) of this subchapter.

(j) *Operational instructions.* QHP issuers must follow the transaction rules established by the Exchange in accordance with § 155.430(e) of this subchapter.

§ 156.272 Issuer participation for the full plan year.

(a) An issuer offering a QHP through an individual market Exchange must make the QHP available for enrollment through the Exchange for the full plan year for which the plan was certified, including to eligible enrollees during limited open enrollment periods, unless a basis for suppression under § 156.815 applies.

(b) Unless a basis for suppression under § 156.815 applies, an issuer offering a QHP through a SHOP must make the QHP available for enrollment through the SHOP for the full plan year for which the QHP was certified.

(c) An issuer offering a QHP through a Federally-facilitated Exchange or a Federally-facilitated SHOP that does not comply with paragraph (a) or (b) of this section may, at the discretion of HHS, be precluded from offering QHPs in a Federally-facilitated Exchange or Federally-facilitated SHOP for up to the two succeeding plan years.

§ 156.275 Accreditation of QHP issuers.

(a) *General requirement.* A QHP issuer must:

(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;

(ii) Patient experience ratings on a standardized CAHPS survey;

(iii) Consumer access;

(iv) Utilization management;

(v) Quality assurance;

(vi) Provider credentialing;

(vii) Complaints and appeals;

(viii) Network adequacy and access; and

(ix) Patient information programs, and

(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with § 155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

(c) *Accreditation*—(1) *Recognition of accrediting entity by HHS*—(i) *Application.* An accrediting entity may apply to HHS for recognition. An application must include the documentation described in paragraph (c)(4) of this section and demonstrate, in a concise and organized fashion how the accrediting entity meets the requirements of paragraphs (c)(2) and (3) of this section.

(ii) *Proposed notice.* Within 60 days of receiving a complete application as described in paragraph (c)(1)(i) of this section, HHS will publish a notice in the **Federal Register** identifying the accrediting entity making the request, summarizing HHS's analysis of whether the accrediting entity meets the criteria described in paragraphs (c)(2) and (3) of this section, and providing no less than a 30-day public comment period about whether HHS should recognize the accrediting entity.

(iii) *Final notice.* After the close of the comment period described in paragraph (c)(1)(ii) of this section, HHS will notify the public in the **Federal Register** of the names of the accrediting entities recognized and those not recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs.

(iv) *Other recognition.* Upon completion of conditions listed in paragraphs (c)(2), (3), and (4) of this section, HHS recognized, and provided notice to the public in the **Federal Register**, the National Committee for Quality Assurance (NCQA) and URAC as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirement of this section.

(2)(i) *Scope of accreditation.* Subject to paragraphs (c)(2)(ii), (iii), and (iv) of this section, recognized accrediting entities must provide accreditation within the categories identified in paragraphs (a)(1) of this section.

(ii) *Clinical quality measures.* Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that:

(A) Spans a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care.

(B) Includes measures that are applicable to adults and measures that are applicable to children.

(C) Aligns with the priorities of the National Strategy for Quality Improvement in Health Care issued by the Secretary of HHS and submitted to Congress on March 12, 2011;

(D) Only includes measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement of Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A–119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and

(E) Is evidence-based.

(iii) *Level of accreditation.* Recognized accrediting entities must provide accreditation at the Exchange product type level unless the product type level of accreditation is not methodologically sound. In such cases, the recognized accrediting entity must demonstrate that the Exchange product type level accreditation is not methodologically sound as a condition of the Exchange granting an exception to authorize accreditation at an aggregated level.

(iv) *Network adequacy.* The network adequacy standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network adequacy for QHP issuers codified in § 156.230(a)(2) and (a)(3).

(3) *Methodological and scoring criteria for accreditation.* Recognized accrediting entities must use transparent and rigorous methodological and scoring criteria.

(4) *Documentation.* An accrediting entity applying to be recognized under the process described in (c)(1) of this section must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes and measure specifications for performance measures to demonstrate that it meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS.

(ii) Recognized accrediting entities must provide to HHS any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days notice prior to public notification.

(5) *Data sharing requirements between the recognized accrediting entities and Exchanges.* When authorized by an accredited QHP issuer pursuant to paragraph (a)(2) of this section, recognized accrediting entities must provide the following QHP issuer's accreditation survey data elements to the Exchange, other than personally identifiable information (as described in OMB Memorandum M–07–16), in which the issuer plans to operate one or more QHPs during the annual certification period or as changes occur to these data throughout the coverage year—the name, address, Health Insurance Oversight System (HIOS) issuer identifier, and unique accreditation identifier(s) of the QHP issuer and its accredited product line(s) and type(s) which have been released; and for each accredited product type:

(i) HIOS product identifier (if applicable);

(ii) Accreditation status, survey type, or level (if applicable);

(iii) Accreditation score;

(iv) Expiration date of accreditation; and

(v) Clinical quality measure results and adult and child CAHPS measure survey results (and corresponding expiration dates of these data) at the level specified by the Exchange.

§ 156.280 Segregation of funds for abortion services.

(a) *State opt-out of abortion coverage.* A QHP issuer must comply with a State law that prohibits abortion coverage in QHPs.

(b) *Termination of opt out.* A QHP issuer may provide coverage of abortion services through the Exchange in a State described in paragraph (a) of this section if the State repeals such law.

(c) *Voluntary choice of coverage of abortion services.* Notwithstanding any other provision of title I of the Affordable Care Act (or any other amendment made under that title):

(1) Nothing in title I of the Affordable Care Act (or any amendments by that title) shall be construed to require a QHP issuer to provide coverage of services described in paragraph (d) of this section as part of its essential health benefits, as described in section 1302(b) of the Affordable Care Act, for any plan year.

(2) Subject to paragraphs (a) and (b) of this section, the QHP issuer must determine whether or not the QHP provides coverage of services described in paragraph (d) of this section as part of such benefits for the plan year.

(d) *Abortion services.* (1) *Abortions for which public funding is prohibited.* The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is not permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(2) *Abortions for which public funding is allowed.* The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(e) *Prohibition on the use of Federal funds.* (1) If a QHP provides coverage of services described in paragraph (d)(1) of this section, the QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

(i) The credit under section 36B of the Code and the amount (if any) of the advance payment of the credit under section 1412 of the Affordable Care Act;

(ii) Any cost-sharing reduction under section 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under section 1412 of the Affordable Care Act.

(2) *Establishment of allocation accounts.* In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:

(i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

(ii) An issuer will be considered to satisfy the obligation in paragraph (e)(2)(i) of this section if it sends the policy holder a single monthly invoice or bill that separately itemizes the premium amount for coverage of abortion services described in paragraph (d)(1) of this section; sends the policy holder a separate monthly bill for these services; or sends the policy holder a notice at or soon after the time of enrollment that the monthly invoice or bill will include a separate charge for such services, and specifies the charge.

(iii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under paragraph (e)(2)(i) of this section shall each be paid by a separate deposit.

(3) *Segregation of funds.* (i) The QHP issuer to which paragraph (e)(1) of this section applies must establish allocation accounts described in paragraph (e)(3)(ii) of this section for enrollees receiving the amounts described in paragraph (e)(1) of this section.

(ii) *Allocation accounts.* The QHP issuer to which paragraph (e)(1) of this section applies must deposit:

(A) All payments described in paragraph (e)(2)(i)(A) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services other than the services described in paragraph (d)(1) of this section;

(B) All payments described in paragraph (e)(2)(i)(B) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (d)(1) of this section.

(4) *Actuarial value.* The QHP issuer must estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the QHP of services described in paragraph (d)(1) of this section. In making such an estimate, the QHP issuer:

(i) May take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) Must estimate such costs as if such coverage were included for the entire population covered; and

(iii) May not estimate such a cost at less than one dollar per enrollee, per month.

(5) *Ensuring compliance with segregation requirements.* (i) Subject to paragraph (e)(5)(iv) of this section, the QHP issuer must comply with the efforts or direction of the State health insurance commissioner to ensure compliance with this section through the segregation of QHP funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget and guidance on accounting of the Government Accountability Office.

(ii) Each QHP issuer that participates in an Exchange and offers coverage for services described in paragraph (d)(1) of this section should, as a condition of participating in an Exchange, submit a plan that details its process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) (hereinafter, "segregation plan") to the State health insurance commissioner. The segregation plan should describe the QHP issuer's financial accounting systems, including appropriate accounting documentation and internal controls, that would ensure the segregation of funds required by section 1303(b)(2)(C), (D), and (E), and should include:

(A) The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of services described in paragraph (d)(1) of this section from those received for coverage of all other services;

(B) The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for services described in paragraph (d)(1) of this section are reimbursed from the appropriate account; and

(C) An explanation of how the QHP issuer's systems, accounting documentation, and controls meet the

requirements for segregation accounts under the law.

(iii) Each QHP issuer participating in the Exchange must provide to the State insurance commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations.

(iv) Nothing in this clause shall prohibit the right of an individual or QHP issuer to appeal such action in courts of competent jurisdiction.

(f) *Rules relating to notice.* (1) *Notice.* A QHP that provides for coverage of services in paragraph (d)(1) of this section, must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

(2) *Rules relating to payments.* The notice described in paragraph (f)(1) of this section, any advertising used by the QHP issuer with respect to the QHP, any information provided by the Exchange, and any other information specified by HHS must provide information only with respect to the total amount of the combined payments for services described in paragraph (d)(1) of this section and other services covered by the QHP.

(g) *No discrimination on basis of provision of abortion.* No QHP offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(h) *Application of State and Federal laws regarding abortions.* (1) *No preemption of State laws regarding abortion.* Nothing in the Affordable Care Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) *No effect on Federal laws regarding abortion.* Nothing in the Affordable Care Act shall be construed to have any effect on Federal laws regarding:

(i) Conscience protection;

(ii) Willingness or refusal to provide abortion; and

(iii) Discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) *No effect on Federal civil rights law.* Nothing in section 1303(c) of the Affordable Care Act shall alter the rights and obligations of employees and employers under Title VII of the Civil Rights Act of 1964.

(i) *Application of emergency services laws.* Nothing in the Affordable Care Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Act (popularly known as "EMTALA").

§ 156.285 Additional standards specific to SHOP for plan years beginning prior to January 1, 2018.

(a) *SHOP rating and premium payment requirements.* QHP issuers offering a QHP through a SHOP must:

(1) Accept payment from the SHOP on behalf of a qualified employer or an enrollee in accordance with § 155.705(b)(4) of this subchapter;

(2) Adhere to the SHOP timeline for rate setting as established in § 155.705(b)(6) of this subchapter; and

(3) Charge the same contract rate for a plan year.

(4)(i) Adhere to the premium rating standards described in § 147.102 of this subchapter regardless of whether the QHP being sold through the SHOP is sold in the small group market or the large group market; and

(ii) Effective in plan years beginning on or after January 1, 2015, a QHP issuer in a Federally-facilitated SHOP may not offer to an employer premiums that are based on average enrollee premium amounts under § 147.102(c)(3) of this subchapter, if the employer elects to offer coverage to its employees under § 155.705(b)(3)(iv)(A) of

this subchapter. This paragraph (a)(4)(ii) also applies to stand-alone dental plans in a Federally-facilitated SHOP, if the employer elects to offer coverage to its employees under § 155.705(b)(3)(v)(B) of this subchapter.

(b) *Enrollment periods for the SHOP*. QHP issuers offering a QHP through the SHOP must:

(1) Enroll a qualified employee in accordance with the qualified employer's initial and annual employee open enrollment periods described in § 155.725 of this subchapter;

(2) Provide special enrollment periods as described in § 155.725(j);

(3) Provide an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period as described in § 155.725(g) of this subchapter; and

(4) Adhere to effective dates of coverage established in accordance with § 155.725 of this subchapter.

(c) *Enrollment process for the SHOP*. A QHP issuer offering a QHP through the SHOP must:

(1) Adhere to the enrollment timeline and process for the SHOP as described in § 155.720(b) of this subchapter;

(2) Receive enrollment information in an electronic format, in accordance with the requirements in §§ 155.260 and 155.270 of this subchapter, from the SHOP as described in § 155.720(c);

(3) Notify new enrollees of their effective date of coverage consistent with § 155.720(e) of this subchapter.

(4) Provide new enrollees with the enrollment information package as described in § 156.265(e);

(5) Send enrollment reconciliation files on at least a monthly basis, and, in a Federally-facilitated SHOP, according to a process, timeline, and file format established by the Federally-facilitated SHOP;

(6) Acknowledge receipt of enrollment information in accordance with SHOP standards; and

(7) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(8) A QHP issuer must enroll a qualified employee only if the SHOP—

(i) Notifies the QHP issuer that the employee is a qualified employee;

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter; and

(iii) Effective for QHPs offered through a Federally-facilitated SHOP in plan years beginning on or after January 1, 2015, does not send a cancellation notice to the QHP issuer prior to the effective date of coverage.

(d) *Termination of coverage or enrollment in the SHOP*. QHP issuers offering a QHP through the SHOP must:

(1) Comply with the following requirements with respect to termination of enrollees in the SHOP:

(i)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage or enrollment established in § 155.735 of this subchapter, if applicable to the coverage or enrollment being terminated; otherwise

(B) General requirements regarding termination of coverage or enrollment established in § 156.270(a).

(ii) [*Effective prior to January 1, 2016*] Requirements for notices to be provided to enrollees and qualified employers in § 156.270(b) and § 156.290(b); and

(ii) [*Effective beginning on January 1, 2016*] If a QHP issuer terminates an enrollee's coverage or enrollment through the SHOP in accordance with § 155.735(d)(1)(iii) or (v) of this subchapter, the QHP issuer must notify the qualified employer and the enrollee of the termination. Such notice must include the

termination effective date and reason for termination, and must be sent within 3 business days if an electronic notice is sent, and within 5 business days if a mailed hard copy notice is sent. When a primary subscriber and his or her dependents live at the same address, a separate termination notice need not be sent to each dependent at that address, provided that the notice sent to each primary subscriber at that address contains all required information about the termination for the primary subscriber and his or her dependents at that address.

(iii)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage or enrollment effective dates as set forth in § 155.735 of this subchapter, if applicable to the coverage or enrollment being terminated; otherwise—

(B) Requirements regarding termination of coverage or enrollment effective dates as set forth in § 156.270(i).

(2) [Reserved]

(e) *Participation rules.* QHP issuers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP only if and to the extent authorized by the SHOP in accordance with § 155.705 of this subchapter.

(f) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Additional standards specific to SHOP for plan years beginning on or after January 1, 2018 are in § 156.286.

§ 156.286 Additional standards specific to SHOP for plan years beginning on or after January 1, 2018.

(a) *SHOP rating and premium payment requirements.* QHP issuers offering a QHP through a SHOP must:

(1) Accept payment from a qualified employer or an enrollee, or a SHOP on behalf of a qualified employer or enrollee, in accordance with applicable SHOP requirements.

(2) Adhere to the SHOP timeline for rate setting as established in § 155.706(b)(6) of this subchapter;

(3) Charge the same contract rate for a plan year; and

(4) Adhere to the premium rating standards described in § 147.102 of this subchapter regardless of whether the QHP being sold through the SHOP is sold in the small group market or the large group market.

(b) *Enrollment periods and processes for the SHOP.* QHP issuers offering a QHP through the SHOP must adhere to enrollment periods and processes established by the SHOP, consistent with § 155.726 of this subchapter, and establish a uniform enrollment timeline and process for enrolling qualified employers and employer group members.

(c) *Enrollment process for the SHOP.* A QHP issuer offering a QHP through the SHOP must:

(1) Provide new enrollees with the enrollment information package as described in § 156.265(e); and

(2) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(d) *Participation rules.* QHP issuers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP only if and to the extent authorized by the SHOP in accordance with § 155.706 of this subchapter.

(e) *Employer choice.* QHP issuers offering a QHP through the SHOP must accept enrollments from groups in accordance with the employer choice policies applicable to the SHOP under § 155.706(b)(3) of this subchapter.

(f) *Identification of SHOP enrollments.* QHP issuers offering a QHP through the SHOP must use a uniform enrollment form, maintain processes sufficient to identify whether a group market enrollment is an enrollment through the SHOP, and maintain records of SHOP enrollments for a period of 10 years following the enrollment.

(g) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

§ 156.290 Non-certification and decertification of QHPs.

(a) *Non-certification for a subsequent, consecutive certification cycle.* If a QHP issuer elects not to seek certification for a subsequent, consecutive certification cycle with the Exchange, the QHP issuer, at a minimum, must—

(1) Notify the Exchange of its decision prior to the beginning of the recertification process and adhere to the procedures adopted by the Exchange in accordance with § 155.1075 of this subchapter;

(2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year through the Exchange;

(3) Fulfill data reporting obligations from the last plan or benefit year of the certification;

(4) Provide notice to enrollees as described in paragraph (b) of this section; and

(5) Terminate the coverage or enrollment through the Exchange of enrollees in the QHP in accordance with § 156.270, as applicable.

(b) *Notice of QHP non-availability.* When, for a subsequent, consecutive certification cycle, a QHP issuer elects not to seek certification with the Exchange, or the Exchange denies certification of a QHP, the QHP issuer must provide written notice to each enrollee in the form and manner specified by the Secretary under § 147.106 of this subchapter.

(c) *Decertification.* If a QHP is decertified by the Exchange, the QHP issuer must terminate the enrollment of enrollees through the Exchange only after:

(1) The Exchange has made notification as described in § 155.1080 of this subchapter; and

(2) Enrollees have an opportunity to enroll in other coverage.

§ 156.295 Prescription drug distribution and cost reporting by QHP issuers.

(a) *General requirement.* In a form, manner, and at such times specified by HHS, a QHP issuer that administers a prescription drug benefit without the use of a pharmacy benefit manager must provide to HHS the following information:

(1) The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed;

(2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding bona fide service fees) that the QHP issuer negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed.

(i) Bona fide service fees means fees paid by a manufacturer to an entity that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

(ii) [Reserved]

(b) *Limitation on disclosure.* Information disclosed by a QHP issuer under this section shall not be disclosed by HHS, except that HHS may disclose the information in a form which does not disclose the identity of a specific QHP or prices charged for specific drugs, for the following purposes:

(1) As HHS determines to be necessary to carry out section 1150A or part D of title XVIII of the Act;

(2) To permit the Comptroller General to review the information provided;

(3) To permit the Director of the Congressional Budget Office to review the information provided; or

(4) To States to carry out section 1311 of the Affordable Care Act.

(c) *Penalties.* A QHP issuer that fails to report the information described in paragraph (a) of this section to HHS on a timely basis or knowingly provides false information will be subject to the provisions of subsection (b)(3)(C) of section 1927 of the Act.

SUBPART D—STANDARDS FOR QUALIFIED HEALTH PLAN ISSUERS FOR SPECIFIC TYPES OF EXCHANGES

§ 156.330 Changes of Ownership of Issuers of Qualified Health Plans in Federally-facilitated Exchanges.

When a QHP issuer that offers one or more QHPs in a Federally-facilitated Exchange undergoes a change of ownership as recognized by the State in which the issuer offers the QHP, the QHP issuer must notify HHS of the change in a manner to be specified by HHS, and provide the legal name and Taxpayer Identification Number (TIN) of the new owner and the effective date of the change at least 30 days prior to the effective date of the change of ownership. The new owner must agree to adhere to all applicable statutes and regulations.

§ 156.340 Standards for downstream and delegated entities.

(a) *General requirement.* Effective October 1, 2013, notwithstanding any relationship(s) that a QHP issuer may have with delegated and downstream entities, a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities with all applicable Federal standards related to Exchanges. The applicable standards depend on the Exchange model type in which the QHP is offered, as described in paragraphs (a)(1) and (2) of this section.

(1) QHP issuers participating in Exchange models that do not use the Federal platform, including State Exchanges and State Exchange SHOPs. QHP issuers maintain responsibility for ensuring their downstream and delegated entities comply with the Federal standards related to Exchanges, including the standards in subpart C of this part with respect to each of its QHPs on an ongoing basis, as well as the Exchange processes, procedures, and standards in accordance with subparts H and K of part 155 and, in the small group market, §§ 155.705 and 155.706 of this subchapter, unless the standard is specifically applicable to a Federally-facilitated Exchange or FF–SHOP;

(2) QHP issuers participating in Exchanges that use the Federal platform, including Federally-facilitated Exchanges, FF–SHOPs, SBE–FPs, and SBE–FP–SHOPs. QHP issuers maintain responsibility for ensuring their downstream and delegated entities comply with Federal standards related to Exchanges, including the standards in subpart C of part 156 with respect to each of its QHPs on an ongoing basis, as well as the Exchange processes, procedures, and standards in accordance with subparts H and K of part 155 of this subchapter and, in the small group market, §§ 155.705 and 155.706 of this subchapter if applicable to the Exchange type in which the QHP issuer is operating. QHP issuers are also responsible for their downstream and delegated entities' compliance with the standards of § 155.220 of this subchapter with respect to assisting with enrollment in QHPs, and the standards of §§ 156.705 and 156.715 of this subchapter for maintenance of records and compliance reviews if applicable to the Exchange type in which the QHP issuer is operating.

(b) *Delegation agreement specifications.* If any of the QHP issuer's activities or obligations, in accordance with paragraph (a) of this section, are delegated to other parties, the QHP issuer's agreement with any delegated or downstream entity must—

(1) Specify the delegated activities and reporting responsibilities;

(2) Provide for revocation of the delegated activities and reporting standards or specify other remedies in instances where HHS or the QHP issuer determines that such parties have not performed satisfactorily;

(3) Specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under paragraph (a) of this section;

(4) Specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through an audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period;

(5) All agreements between issuers offering QHPs through an Exchange and delegated or downstream entities the issuers engage to support the issuer's activities on an Exchange must include language stating that the relevant Exchange authority may demand and receive the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period.

§ 156.350 Eligibility and enrollment standards for Qualified Health Plan issuers on State-based Exchanges on the Federal platform.

(a) In order to participate in a State-based Exchange on the Federal platform, a QHP issuer must comply with HHS regulations, and guidance pertaining to issuer eligibility and enrollment functions as if the issuer were an issuer of a QHP on a Federally-facilitated Exchange. These requirements include—

(1) Section 156.285(a)(4)(ii) regarding the premiums for plans offered on the SHOP, for plan years beginning prior to January 1, 2018;

(2) Section 156.285(c)(5) and (c)(8)(iii) regarding the enrollment process for SHOP, for plan years beginning prior to January 1, 2018; and [*sic*—"and" probably should be deleted]

(3) Section 156.715 regarding compliance reviews of QHP issuers, to the extent relating directly to applicable eligibility and enrollment functions. [*sic*—probably should be "; and"]

(4) Section 156.265(d) of this subchapter regarding binder payments and premium payment deadlines.

(b) HHS will permit issuers of QHPs in each State-based Exchange on the Federal platform to directly enroll applicants in a manner that is considered to be through the Exchange, as if the issuers were issuers of QHPs on Federally-facilitated Exchanges under § 156.1230(a), to the extent permitted by applicable State law.

(c) If the State-based Exchange on the Federal platform does not substantially enforce a requirement in paragraph (a) of this section against the issuer or plan, then HHS may do so, in accordance with the enforcement remedies in subpart I of this part, subject to the administrative review process in subpart J of this part.

SUBPART E—HEALTH INSURANCE ISSUER RESPONSIBILITIES WITH RESPECT TO ADVANCE PAYMENTS OF THE PREMIUM TAX CREDIT AND COST-SHARING REDUCTIONS

§ 156.400 Definitions.

The following definitions apply to this subpart:

Advance payments of the premium tax credit has the meaning given to the term in § 155.20 of this subchapter.

Affordable Care Act has the meaning given to the term in § 155.20 of this subchapter.

Annual limitation on cost sharing means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

De minimis variation means the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan as established in § 156.140(c).

De minimis variation for a silver plan variation means a –0 percentage point and +1 percentage point allowable AV variation.

Federal poverty level or *FPL* has the meaning given to the term in § 155.300(a) of this subchapter.

Indian has the meaning given to the term in § 155.300(a) of this subchapter.

Limited cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(2).

Maximum annual limitation on cost sharing means the highest annual dollar amount that qualified health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under § 156.130.

Most generous or *more generous* means, as between a QHP (including a standard silver plan) or plan variation and one or more other plan variations of the same QHP, the standard plan or plan variation designed for the category of individuals last listed in § 155.305(g)(3) of this subchapter. *Least generous* or *less generous* has the opposite meaning.

Plan variation means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation.

Reduced maximum annual limitation on cost sharing means the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction, if any, in the maximum annual limitation on cost sharing required by section 1402 of the Affordable Care Act as announced in the annual HHS notice of benefit and payment parameters.

Silver plan variation means, with respect to a standard silver plan, any of the variations of that standard silver plan described in § 156.420(a).

Stand-alone dental plan means a plan offered through an Exchange under § 155.1065 of this subchapter.

Standard plan means a QHP offered at one of the four levels of coverage, defined at § 156.140, with an annual limitation on cost sharing that conforms to the requirements of § 156.130(a). A standard plan at the bronze, silver, gold, or platinum level of coverage is referred to as a standard bronze plan, a standard silver plan, a standard gold plan, and a standard platinum plan, respectively.

Zero cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(1).

§ 156.410 Cost-sharing reductions for enrollees.

(a) *General requirement.* A QHP issuer must ensure that an individual eligible for cost-sharing reductions, as demonstrated by assignment to a particular plan variation, pays only the cost sharing required of an eligible individual for the applicable covered service under the plan variation. The cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected.

(b) *Assignment to applicable plan variation.* If an individual is determined to be eligible to enroll in a QHP in the individual market offered through an Exchange and elects to do so, the QHP issuer must assign the individual under enrollment and eligibility information submitted by the Exchange as follows—

(1) If the individual is determined eligible by the Exchange for cost-sharing reductions under § 155.305(g)(2)(i), (ii), or (iii) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter) and chooses to enroll in a silver health plan, the QHP issuer must assign the individual to the silver plan variation of the selected silver health plan described in § 156.420(a)(1), (2), or (3), respectively.

(2) If the individual is determined eligible by the Exchange for cost-sharing reductions for Indians with lower household income under § 155.350(a) of this subchapter (subject to the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the zero cost sharing plan variation of the selected QHP with all cost sharing eliminated described in § 156.420(b)(1).

(3) If the individual is determined by the Exchange to be eligible for cost-sharing reductions for Indians regardless of household income under § 155.350(b) of this subchapter (subject to the special rule for family policies set

forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the limited cost sharing plan variation of the selected QHP with the prohibition on cost sharing for benefits received from the Indian Health Service and certain other providers described in § 156.420(b)(2).

(4) If the individual is determined by the Exchange not to be eligible for cost-sharing reductions (including eligibility under the special rule for family policies set forth in § 155.305(g)(3) of this subchapter), and chooses to enroll in a QHP, the QHP issuer must assign the individual to the selected QHP with no cost-sharing reductions.

(c) *Improper cost-sharing reductions.* (1) If a QHP issuer fails to ensure that an individual assigned to a plan variation receives the cost-sharing reductions required under the applicable plan variation, taking into account § 156.425(b) concerning continuity of deductibles and out-of-pocket amounts (if applicable), then the QHP issuer must notify the enrollee of the improper application of any cost-sharing reduction within 45 calendar days of discovery of such improper application, and refund any resulting excess cost sharing paid by or for the enrollee as follows:

(i) If the excess cost sharing was paid by the provider, the QHP issuer must refund the excess cost sharing to the provider within 45 calendar days of discovery of the improper application.

(ii) If the excess cost sharing was not paid by the provider and is not requested by the enrollee as a refund, the QHP issuer must, within 45 calendar days of discovery of the error, apply the excess cost sharing paid by or for the enrollee to the enrollee's portion of the premium (or refund the amount directly). If any excess premium remains, the QHP issuer must apply the excess premium to the enrollee's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess is fully applied (or refund any remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, the QHP issuer must refund the enrollee any remaining excess cost sharing paid by or for the enrollee within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(iii) If the excess cost sharing was not paid by the provider, and if a refund is requested by the enrollee, the refund must be provided to the enrollee within 45 calendar days of the date of the request.

(2) If a QHP issuer provides an individual assigned to a plan variation greater cost-sharing reductions than required under the applicable plan variation, taking into account § 156.425(b) concerning continuity of deductibles and out-of-pocket amounts (if applicable), then the QHP issuer will not be eligible for reimbursement of any excess cost-sharing reductions provided to the enrollee, and may not seek reimbursement from the enrollee or the applicable provider for any of the excess cost-sharing reductions.

(d) *Improper assignment.* If a QHP issuer does not assign an individual to the applicable plan variation (or standard plan without cost-sharing reductions) in accordance with § 156.410(b) and § 156.425(a) based on the eligibility and enrollment information or notification provided by the Exchange, then the QHP issuer must reassign the enrollee to the applicable plan variation (or standard plan without cost-sharing reductions) and notify the enrollee of the improper assignment such that:

(1) If the QHP issuer discovers the improper assignment between the first and fifteenth day of the month, the QHP issuer must reassign the enrollee to the correct plan variation (or standard plan without cost-sharing reductions) by the first day of the following month.

(2) If the QHP issuer discovers the improper assignment between the sixteen and the last day of the month, the QHP issuer must reassign the individual to the correct plan variation (or standard plan without cost-sharing reductions) by the first day of the second following month.

(3) If, pursuant to a reassignment under this paragraph (d), a QHP issuer reassigns an enrollee from a more generous plan variation to a less generous plan variation of a QHP (or a standard plan without cost-sharing reductions), the QHP

issuer will not be eligible for reimbursement for any of the excess cost-sharing reductions provided to the enrollee following the effective date of eligibility required by the Exchange, and may not seek reimbursement from the enrollee or the applicable provider for any of the excess cost-sharing reductions.

(4) If, pursuant to a reassignment under this paragraph (d), a QHP issuer reassigns an enrollee from a less generous plan variation (or a standard plan without cost-sharing reductions) to a more generous plan variation of a QHP, the QHP issuer must recalculate the enrollee's liability for cost sharing paid between the effective date of eligibility required by the Exchange and the date on which the issuer effectuated the change, and must refund any excess cost sharing paid by or for the enrollee during such period as follows:

(i) If the excess cost sharing was paid by the provider, the QHP issuer must refund the excess cost sharing to the provider within 45 calendar days of discovery of the improper assignment.

(ii) If the excess cost sharing was not paid by the provider and is not requested by the enrollee as a refund, the QHP issuer must, within 45 calendar days of discovery of the improper assignment, apply the excess cost sharing paid by or for the enrollee to the enrollee's portion of the premium (or refund the amount directly). If any excess premium remains, the QHP issuer must apply the excess premium to the enrollee's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess is fully applied (or refund the remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, the QHP issuer must refund the enrollee any remaining excess cost sharing paid by or for the enrollee within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(iii) If the excess cost sharing was not paid by the provider, then, if the enrollee requests a refund, the refund must be provided to the enrollee within 45 calendar days of the date of the request.

§ 156.420 Plan variations.

(a) *Submission of silver plan variations.* For each of its silver health plans that an issuer offers, or intends to offer in the individual market on an Exchange, the issuer must submit annually to the Exchange for certification prior to each benefit year the standard silver plan and three variations of the standard silver plan, as follows—

(1) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 94 percent plus or minus the de minimis variation for a silver plan variation;

(2) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(ii) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 87 percent plus or minus the de minimis variation for a silver plan variation; and

(3) For individuals eligible for cost-sharing reductions under § 155.305(g)(2)(iii) of this subchapter, a variation of the standard silver plan with:

(i) An annual limitation on cost sharing no greater than the reduced maximum annual limitation on cost sharing specified in the annual HHS guidance or notice of benefit and payment parameters for such individuals, and

(ii) Other cost-sharing reductions such that the AV of the silver plan variation is 73 percent plus or minus the de minimis variation for a silver plan variation (subject to § 156.420(h)).

(b) *Submission of zero and limited cost sharing plan variations.* For each of its health plans at any level of coverage that an issuer offers, or intends to offer in the individual market on an Exchange, the issuer must submit to the Exchange for certification the health plan and two variations of the health plan, as follows—

(1) For individuals eligible for cost-sharing reductions under § 155.350(a) of this subchapter, a variation of the health plan with all cost sharing eliminated; and

(2) For individuals eligible for cost-sharing reductions under § 155.350(b) of this subchapter, a variation of the health plan with no cost sharing on any item or service that is an EHB furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization (each as defined in 25 U.S.C. 1603), or through referral under contract health services.

(c) *Benefit and network equivalence in silver plan variations.* A standard silver plan and each silver plan variation thereof must cover the same benefits and providers. Each silver plan variation is subject to all requirements applicable to the standard silver plan (except for the requirement that the plan have an AV as set forth in § 156.140(b)(2)).

(d) *Benefit and network equivalence in zero and limited cost sharing plan variations.* A QHP and each zero cost sharing plan variation or limited cost sharing plan variation thereof must cover the same benefits and providers. The out-of-pocket spending required of enrollees in the zero cost sharing plan variation of a QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the limited cost sharing plan variation of the QHP and the corresponding out-of-pocket spending required in the silver plan variation of the QHP for individuals eligible for cost-sharing reductions under § 155.305(g)(2)(i) of this subchapter, in the case of a silver QHP. The out-of-pocket spending required of enrollees in the limited cost sharing plan variation of the QHP for a benefit that is not an essential health benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding out-of-pocket spending required in the QHP with no cost-sharing reductions. A limited cost sharing plan variation must have the same cost sharing for essential health benefits not described in paragraph (b)(2) of this section as the QHP with no cost-sharing reductions. Each zero cost sharing plan variation or limited cost sharing plan variation is subject to all requirements applicable to the QHP (except for the requirement that the plan have an AV as set forth in § 156.140(b)).

(e) *Decreasing cost sharing and out-of-pocket spending in higher AV silver plan variations.* The cost sharing or out-of- pocket spending required of enrollees under any silver plan variation of a standard silver plan for a benefit from a provider (including a provider outside the plan's network) may not exceed the corresponding cost sharing or out-of-pocket spending required in the standard silver plan or any other silver plan variation thereof with a lower AV.

(f) *Minimum AV differential between 70 percent and 73 percent silver plan variations.* Notwithstanding any permitted de minimis variation in AV for a health plan or permitted de minimis variation for a silver plan variation, the AVs of a standard silver plan and the silver plan variation thereof described in paragraph (a)(3) of this section must differ by at least 2 percentage points.

(g) *Multi-state plans.* The U.S. Office of Personnel Management will determine the time and manner for multi-State plans, as defined in § 155.1000(a) of this subchapter, to submit silver plan variations, zero cost sharing plan variations, and limited cost sharing plan variations.

(h) *Notice.* No later than November 1, 2015, for each plan variation that an issuer offers in accordance with the rules of this section, an issuer must provide a summary of benefits and coverage that accurately represents each plan variation consistent with the requirements set forth in § 147.200 of this subchapter.

§ 156.425 Changes in eligibility for cost-sharing reductions.

(a) *Effective date of change in assignment.* If the Exchange notifies a QHP issuer of a change in an enrollee's eligibility for cost-sharing reductions (including a change in the individual's eligibility under the special rule for family policies set forth in § 155.305(g)(3) of this subchapter due to a change in eligibility of another individual on the same policy), then the QHP issuer must change the individual's assignment such that the individual is assigned to the applicable standard plan or plan variation of the QHP as required under § 156.410(b) as of the effective date of eligibility required by the Exchange.

(b) *Continuity of deductible and out-of- pocket amounts.* In the case of a change in assignment to a different plan variation (or standard plan without cost-sharing reductions) of the same QHP in the course of a benefit year under this section, the QHP issuer must ensure that any cost sharing paid by the applicable individual under previous plan variations (or standard plan without cost-sharing reductions) for that benefit year is taken into account in the new plan variation (or standard plan without cost-sharing reductions) for purposes of calculating cost sharing based on aggregate spending by the individual, such as for deductibles or for the annual limitations on cost sharing.

(c) *Notice upon assignment.* Beginning on January 1, 2016, if an individual's assignment to a standard plan or plan variation of the QHP changes in accordance with paragraph (a) of this section, the issuer must provide to that individual a summary of benefits and coverage that accurately reflects the new plan variation (or standard plan variation without cost-sharing reductions) in a manner consistent with § 147.200 of this subchapter as soon as practicable following receipt of notice from the Exchange, but not later than 7 business days following receipt of notice.

§ 156.430 Payment for cost-sharing reductions.

(a) [Reserved]

(b) *Advance payments for cost-sharing reductions.*

(1) When there is an appropriation to make cost-sharing reduction payments to QHP issuers, a QHP issuer will receive periodic advance payments from HHS to the extent permitted by the appropriation and calculated in accordance with § 155.1030(b)(3) of this subchapter.

(2) HHS may adjust the advance payment amount for a particular QHP during the benefit year if the QHP issuer provides evidence, certified by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies, that the advance payments for a particular QHP are likely to be substantially different than the cost-sharing reduction amounts that the QHP provides that will be reimbursed by HHS.

(c) *Submission of actual amounts.* (1) *General.* For each plan variation that a QHP issuer offers on the Exchange, it must submit to HHS, in the manner and timeframe established by HHS, for each policy, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by all of the following:

(i) The amount the issuer paid.

(ii) The amount the enrollee(s) paid.

(iii) The amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions.

(2) *Standard methodology.* A QHP issuer must calculate the value of the amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions by applying the actual cost-sharing requirements for the standard plan to the allowed costs for essential health benefits under the enrollee's policy for the benefit year.

(i) For reconciliation of cost-sharing reduction amounts advanced for the 2014 and 2015 benefit years, an issuer of a QHP using the standard or simplified methodology may calculate claims amounts attributable to EHB, including cost sharing amounts attributable to EHB, by reducing total claims amounts by the plan-specific percentage estimate of non-essential health benefit claims submitted on the Uniform Rate Review Template for the corresponding benefit year, if the following conditions are met:

(A) The non-essential health benefits percentage estimate is less than 2 percent; and

(B) Out-of-pocket expenses for non- EHB benefits are included in the calculation of amounts subject to a deductible or annual limitation on cost sharing, but copayments and coinsurance rates on non-EHB benefits are not reduced under the plan variation.

(ii) [Reserved]

(3) *Selection of methodology.* For benefit years 2014 through 2016, notwithstanding paragraph (c)(2) of this section, a QHP issuer may choose to calculate the amounts that would have been paid under the standard plan without cost-sharing reductions using the simplified methodology described in paragraph (c)(4) of this section.

(i) The QHP issuer must notify HHS prior to the start of each benefit year, in the manner and timeframe established by HHS, whether or not it selects the simplified methodology for the benefit year.

(ii) If the QHP issuer selects the simplified methodology, it must apply the simplified methodology to all plan variations it offers on the Exchange for a benefit year.

(iii) The QHP issuer may not select the simplified methodology for a benefit year if the QHP issuer did not select the simplified methodology for the prior benefit year.

(iv) Notwithstanding paragraphs (c)(3)(ii) and (iii) of this section, if a QHP issuer merges with or acquires another issuer of a QHP on the Exchange, or acquires a QHP offered on the Exchange from another QHP issuer, and if one, but not all, of the merging, acquiring, or acquired parties had selected the simplified methodology for the benefit year, then for the benefit year in which the merger or acquisition took place, the QHP issuer must calculate the amounts that would have been paid using the methodology (whether the standard methodology described in paragraph (c)(2) of this section or the simplified methodology described in paragraph (c)(4) of this section) selected with respect to the plan variation prior to the start of the benefit year (even if the selection was not made by that QHP issuer). For the next benefit year (if such benefit year is 2015 or 2016), the QHP issuer may select the simplified methodology (subject to paragraph (c)(3)(ii) of this section but, for that benefit year, not paragraph (c)(3)(iii) of this section) or the standard methodology.

(4) *Simplified methodology.* Subject to paragraph (c)(4)(v) of this section, a QHP issuer that selects the simplified methodology described in this paragraph (c)(4) must calculate the amount that the enrollees would have paid under the standard plan without cost-sharing reductions for each policy that was assigned to a plan variation for any portion of the benefit year by applying each set of the standard plan's effective cost-sharing parameters (as calculated under paragraphs (c)(3)(ii) and (iii) of this section) to the corresponding subgroup of total allowed costs for EHB for the policy (as described in paragraph (c)(4)(i) of this section).

(i) For plan variation policies with total allowed costs for EHB for the benefit year that are:

(A) Less than or equal to the effective deductible, the amount that the enrollees would have paid under the standard plan is equal to the total allowed costs for EHB under the policy for the benefit year multiplied by the effective pre-deductible coinsurance rate.

(B) Greater than the effective deductible but less than the effective claims ceiling, the amount that the enrollees would have paid under the standard plan is equal to the sum of (x) the average deductible, plus (y) the effective non-deductible cost sharing, plus (z) the difference, if positive, between the total allowed costs under the policy for the benefit year for EHB that are subject to a deductible and the average deductible, multiplied by the effective post-deductible coinsurance rate.

(C) Greater than or equal to the effective claims ceiling, the amount that the

enrollees would have paid under the standard plan is equal to the annual limitation on cost sharing for the standard plan (as defined at 45 CFR 156.400), or, at the QHP issuer's election on a policy-by-policy basis, the amount calculated pursuant to the standard methodology described in paragraph (c)(2) of this section,

(ii) The QHP issuer must calculate one or more sets of effective cost-sharing parameters, as described in paragraph (c)(4)(iii) of this section, based on policies assigned to the standard plan without cost-sharing reductions for the entire benefit year and must separately apply each set of effective cost-sharing parameters to the corresponding subgroup of total allowed costs for EHB for each plan variation policy, as described in paragraph (c)(4)(i) of this section, as follows:

(A) If the standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, but does not have separate cost-sharing parameters for pharmaceutical and medical services, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the costs of enrollees in the standard plan with self-only coverage, and based on the costs of enrollees in the standard plan with other than self-only coverage.

(B) If the standard plan has separate cost-sharing parameters for pharmaceutical and medical services, but does not have separate cost-sharing parameters for self-only coverage and other than self-only coverage, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the medical costs of the enrollees in the standard plan, and based on the pharmaceutical costs of the enrollees in the standard plan.

(C) If the standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, and also has separate cost-sharing parameters for pharmaceutical and medical services, the QHP issuer must calculate and apply separate sets of effective cost-sharing parameters based on the medical costs of enrollees in the standard plan with self-only coverage, based on the pharmaceutical costs of enrollees in the standard plan with self-only coverage, based on the medical costs of enrollees in the standard plan with other than self-only coverage, and based on the pharmaceutical costs of enrollees in the standard plan with other than self-only coverage.

(iii) The effective cost-sharing parameters for the standard plan without cost-sharing reductions must be calculated based on policies assigned to the standard plan for the entire benefit year for each of the required subgroups under paragraph (c)(4)(ii) of this section as follows:

(A) If the standard plan has only one deductible (for the applicable subgroup), the average deductible of the standard plan is that deductible amount. If the standard plan has more than one deductible (for the applicable subgroup), the average deductible is the weighted average of the deductibles, weighted by allowed costs for EHB under the standard plan for the benefit year that are subject to each separate deductible. Services that are not subject to any deductible (including services subject to copayments or coinsurance but not any deductible) are not to be incorporated into the calculation of the average deductible.

(B) The effective non-deductible cost sharing for the applicable subgroup is the average portion of total allowed costs for EHB that are not subject to any deductible for the standard plan for the benefit year incurred for standard plan enrollees and payable by the enrollees as cost sharing. The effective nondeductible cost sharing must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the effective deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(C) The effective deductible for the applicable subgroup is equal to the sum of the average deductible and the average total allowed costs for EHB that are not subject to any deductible for the standard plan for the benefit year. The average total allowed costs for EHB that are not subject to any deductible for the standard plan for the benefit year must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the average deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(D) The effective pre-deductible coinsurance rate for the applicable subgroup is the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for standard plan enrollees and payable as cost sharing. The effective pre-deductible coinsurance rate must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are less than or equal to the effective deductible.

(E) The effective post-deductible coinsurance rate for the applicable subgroup is the quotient of (x) the portion of average allowed costs for EHB subject to a deductible incurred for enrollees for the benefit year, and payable by the enrollees as cost sharing other than through a deductible, over the difference of (y) the average allowed costs for EHB subject to a deductible incurred for enrollees for the benefit year, and (z) the average deductible. The effective post-deductible coinsurance rate must be calculated based only on standard plan policies with total allowed costs for EHB for the benefit year that are above the effective deductible but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(F) The effective claims ceiling for the applicable subgroup is calculated as the effective deductible plus the quotient of (x) the difference between the annual limitation on cost sharing and the sum of the average deductible and the effective non-deductible cost sharing, divided by (y) the effective post-deductible coinsurance rate.

(iv) If a QHP issuer uses the simplified methodology described in this paragraph (c)(4), and the QHP issuer's standard plan does not meet any of the criteria in paragraphs (c)(4)(v)(A) through (D) of this section, the QHP issuer must also submit to HHS, in the manner and timeframe established by HHS, the following information for each standard plan offered by the QHP issuer in the individual market through the Exchange for each of the required subgroups described in paragraph (c)(4)(ii) of this section:

(A) The average deductible for each applicable subgroup;

(B) The effective deductible for each applicable subgroup;

(C) The effective non-deductible cost sharing amount for each applicable subgroup;

(D) The effective pre-deductible coinsurance rate for each applicable subgroup;

(E) The effective post-deductible coinsurance rate for each applicable subgroup;

(F) The effective claims ceiling for each applicable subgroup; and

(G) A memorandum developed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies that describes how the QHP issuer calculated the effective cost-sharing parameters for each applicable subgroup for the standard plan.

(v) Notwithstanding paragraphs (c)(4)(i) through (iii) of this section, if a QHP issuer's standard plan meets the criteria in any of the following subparagraphs, and the QHP issuer

has selected the simplified methodology described in this paragraph (c)(4), then the QHP issuer must calculate the amount that the enrollees in the plan variation would have paid under the standard plan without cost-sharing reductions as the lesser of the annual limitation on cost sharing for the standard plan or the amount equal to the product of, (x) one minus the standard plan's actuarial value, as calculated under 45 CFR 156.135, and (y) the total allowed costs for EHB for the benefit year under each policy that was assigned to a plan variation for any portion of the benefit year.

(A) The standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage, does not have separate cost-sharing parameters for pharmaceutical and medical services, and has an enrollment during the benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in either of the following categories –

(*1*) Self-only coverage; or

(*2*) Other than self-only coverage.

(B) The standard plan has separate cost-sharing parameters for pharmaceutical and medical services, does not have separate cost-sharing parameters for self-only coverage and other than self-only coverage, and has an enrollment during the benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in either of the following categories:

(*1*) Coverage of medical services; or

(*2*) Coverage of pharmaceutical services.

(C) The standard plan has separate cost-sharing parameters for self-only coverage and other than self-only coverage and for pharmaceutical and medical services, and has an enrollment during the benefit year of fewer than 12,000 member months for coverage with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing, in any of the following categories:

(*1*) Self-only coverage of medical services;

(*2*) Self-only coverage of pharmaceutical services;

(*3*) Other than self-only coverage of medical services; or

(*4*) Other than self-only coverage of pharmaceutical services.

(D) The standard plan does not have separate cost-sharing parameters for pharmaceutical and medical services, or for self-only coverage and other than self-only coverage, and has an enrollment during the benefit year of fewer than 12,000 member months with total allowed costs for EHB for the benefit year that are greater than the effective deductible, but for which associated cost sharing for EHB is less than the annual limitation on cost sharing.

(vi) Notwithstanding paragraphs (c)(4)(i)(A) and (B) of this section, and paragraphs (c)(4)(iii)(A) through (E) of this section, if more than eighty percent of the total allowed costs for EHB for the benefit year under a standard plan for a subgroup that requires a separate set of effective cost-sharing parameters pursuant to paragraph (c)(4)(ii) are not subject to a deductible, then:

(A) The average deductible, the effective non-deductible cost sharing, and the effective deductible for the subgroup equal zero;

(B) The effective pre-deductible coinsurance rate for the subgroup is equal to the effective post-deductible coinsurance rate for the subgroup, which is determined based on all standard plan policies for the applicable subgroup for which associated cost sharing for EHB is less than the annual limitation on cost sharing, and calculated for the applicable subgroup as the proportion of the total allowed costs for EHB under the standard plan for the benefit year incurred for standard plan enrollees and payable as cost sharing (including cost sharing payable through a deductible); and

(C) The amount that enrollees in the applicable subgroup in plan variation policies with total allowed costs for EHB for the benefit year that are less than the effective claims ceiling would have paid under the standard plan must be calculated using the formula in paragraph (c)(4)(i)(A).

(5) *Reimbursement of providers.* In the case of a benefit for which the QHP issuer compensates an applicable provider in whole or in part on a fee-for-service basis, allowed costs associated with the benefit may be included in the calculation of the amount that an enrollee(s) would have paid under the standard plan without cost-sharing reductions only to the extent the amount was either payable by the enrollee(s) as cost sharing under the plan variation or was reimbursed to the provider by the QHP issuer.

(d) *Cost-sharing reductions data submissions.* HHS will periodically provide a submission window for issuers to submit cost-sharing reduction data documenting cost-sharing reduction amounts issuers paid, as specified in paragraphs (d)(1) and (2) of this section, in a form and manner specified by HHS in guidance, calculated in accordance with paragraph (c) of this section. When HHS makes cost-sharing reduction payments to QHP issuers, HHS will notify QHP issuers that the submission of the cost-sharing data is mandatory for those issuers having received cost-sharing reduction payments for any part of the benefit year and voluntary for other issuers, and HHS will use the data to reconcile advance cost-sharing reduction payments to issuers against the actual amounts of cost-sharing reductions QHP issuers provided, as determined by HHS based on amounts specified in paragraphs (d)(1) and (2) of this section, as calculated in accordance with paragraph (c) of this section. In the absence of an appropriation to make cost-sharing reduction payments to issuers, HHS will notify QHP issuers that the submission of the cost-sharing data is voluntary. The cost-sharing data that must be submitted in either a voluntary or mandatory submission includes:

(1) The actual amount of cost-sharing reductions provided to enrollees and reimbursed to providers by the QHP issuer for benefits for which the QHP issuer compensates the applicable providers in whole or in part on a fee-for-service basis; and

(2) The actual amount of cost-sharing reductions provided to enrollees for benefits for which the QHP issuer compensates the applicable providers in any other manner.

(e) *Cost-sharing reductions payments and charges.* If the actual amounts of cost-sharing reductions determined by HHS based on amounts described in paragraphs (d)(1) and (2) of this section are—

(1) More than the amount of advance payments HHS provided, and the QHP issuer has timely provided the data of actual amounts of cost-sharing reductions as required under paragraph (c) of this section, if an appropriation is available to make cost-sharing payments to QHP issuers, HHS will make a payment to the QHP issuer for the difference; or

(2) Less than the amount of advance payments provided, the QHP issuer must repay the difference to HHS in the manner and timeframe specified by HHS.

(f) *Cost-sharing reductions during special periods.* (1) Notwithstanding the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will not be eligible for reimbursement of any cost-sharing reductions provided following a termination of coverage effective date with respect to a grace period as described in § 155.430(b)(2)(ii)(A) or (B) of this subchapter. However, the QHP issuer will be eligible for reimbursement of cost-sharing reductions provided prior to the termination of coverage effective date. Advance payments of cost-sharing reductions will be paid to a QHP issuer prior to a

determination of termination (including during any grace period, but the QHP issuer will be required to repay any advance payments made with respect to any month after any termination of coverage effective date during a grace period).

(2) Notwithstanding the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the termination (or the late determination thereof) is the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will not be eligible for advance payments and reimbursement for cost-sharing reductions provided during the period following the termination of coverage effective date and prior to the determination of the termination.

(3) Subject to the requirements of the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the reason for the termination (or late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period.

(4) Subject to the requirements of the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility for enrollment under § 155.315(f) of this subchapter.

(g) *Prohibition on reduction in payments to Indian health providers.* If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in § 156.410(b)(2) and (3).

(h) *Reconciliation of the cost-sharing reduction portion of advance payments discrepancies and appeals.* (1) If an issuer reports a discrepancy and seeks to dispute the notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments, it must report the discrepancy to HHS within 30 calendar days of notification of the amount of reconciliation of the cost-sharing reduction portion of advance payments as described in paragraph (e) of this section, in the manner set forth by HHS.

(2) An issuer may appeal the amount of reconciliation of the cost-sharing reduction portion of advance payments, under the process set forth in § 156.1220.

§ 156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.

Except as noted in paragraph (a) through (c) of this section, the provisions of this subpart apply to qualified health plans offered in the individual market on the Exchange.

(a) *Catastrophic plans.* The provisions of this subpart do not apply to catastrophic plans described in § 156.155.

(b) *Stand-alone dental plans.* The provisions of this subpart, to the extent relating to cost-sharing reductions, do not apply to stand-alone dental plans. The provisions of this subpart, to the extent relating to advance payments of the premium tax credit, apply to standalone dental plans.

(c) *Child-only plans.* The provisions of this subpart apply to child-only QHPs, described in § 156.200(c)(2).

§ 156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.

(a) *Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.* A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's

QHP is eligible for an advance payment of the premium tax credit must—

(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;

(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with § 156.265(g); and

(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.

(b) *Delays in payment.* A QHP issuer may not refuse to commence coverage under a policy or terminate coverage on account of any delay in payment of an advance payment of the premium tax credit on behalf of an enrollee if the QHP issuer has been notified by the Exchange under § 155.340(a) of this subchapter that the QHP issuer will receive such advance payment.

(c) *Refunds to enrollees for improper reduction of enrollee's share of premium to account for advance payments of the premium tax credit.* If a QHP issuer discovers that it did not reduce the portion of the premium charged to or for an enrollee for the applicable month(s) by the amount of the advance payment of the premium tax credit in accordance with paragraph (a)(1) of this section, the QHP issuer must notify the enrollee of the improper reduction within 45 calendar days of the QHP issuer's discovery of the improper reduction and refund any excess premium paid by or for the enrollee, as follows:

(1) Unless a refund is requested by or for the enrollee, the QHP issuer must, within 45 calendar days of discovery of the error, apply the excess premium paid by or for the enrollee to the enrollee's portion of the premium (or refund the amount directly). If any excess premium remains, the QHP issuer must apply the excess premium to the enrollee's portion of the premium for each subsequent month for the remainder of the period of enrollment or benefit year until the excess is fully applied (or refund the remaining amount directly). If any excess premium remains at the end of the period of enrollment or benefit year, the QHP issuer must refund any excess premium within 45 calendar days of the end of the period of enrollment or benefit year, whichever comes first.

(2) If a refund is requested by or for the enrollee, the refund must be provided within 45 calendar days of the date of the request.

§ 156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.

(a) *Allocation to additional health benefits for QHPs.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or intended to be offered, in the individual market on an Exchange, an allocation of the rate for the plan to:

(1) EHB, other than services described in § 156.280(d)(1); and

(2) Any other services or benefits offered by the health plan not described in paragraph (a)(1) of this section.

(b) *Allocation to additional health benefits for stand-alone dental plans.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange, a dollar allocation of the expected premium for the plan, to:

(1) The pediatric dental essential health benefit, and

(2) Any benefits offered by the standalone dental plan that are not the pediatric dental essential health benefit.

(c) *Allocation standards for QHPs.* The issuer must ensure that the allocation described in paragraph (a) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Reasonably reflects the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in § 156.280(d)(1));

(3) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under § 155.170(c) of this subchapter, and the allocation requirements described in § 156.280(e)(4) for certain services; and

(4) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, the single risk pool standards described at 45 CFR 156.80, and the same premium rate standards described at 45 CFR 156.255.

(d) *Allocation standards for standalone dental plans.* The issuer must ensure that the dollar allocation described in paragraph (b) of this section is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

(e) *Disclosure of attribution and allocation methods.* An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange must submit to the Exchange annually for approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

(f) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must submit the allocations and actuarial memorandum described in this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

§ 156.480 Oversight of the administration of the advance payments of the premium tax credit, cost-sharing reductions, and user fee programs.

(a) *Maintenance of records.* An issuer that offers a QHP in the individual market through a State Exchange must adhere to, and ensure that any relevant delegated entities and downstream entities adhere to, the standards set forth in § 156.705 concerning maintenance of documents and records, whether paper, electronic, or in other media, by issuers offering QHPs in a Federally-facilitated Exchange, in connection with cost-sharing reductions and advance payments of the premium tax credit.

(b) *Annual reporting requirements.* For each benefit year, an issuer that offers a QHP in the individual market through an Exchange must report to HHS, in the manner and timeframe required by HHS, summary statistics specified by HHS with respect to administration of cost-sharing reduction and advance payments of the premium tax credit programs, including any failure to adhere to the standards set forth under § 156.410(a) through (d), § 156.425(a) through (b), and § 156.460(a) through (c) of this Part.

(c) *Audits and compliance reviews.* HHS or its designee may audit or conduct a compliance review of an issuer offering a QHP through an Exchange to assess its compliance with the applicable requirements of this subpart and 45 CFR 156.50. Compliance reviews conducted under this section will follow the standards set forth in § 156.715.

(1) *Notice of audit.* HHS will provide at least 30 calendar days advance notice of its intent to conduct an audit of an issuer under this section.

(i) *Conferences.* All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed.

(ii) [Reserved]

(2) *Compliance with audit activities.* To comply with an audit under this section, the issuer must:

(i) Ensure that its relevant employees, agents, contractors, subcontractors, downstream entities, and delegated entities cooperate with any audit or compliance review under this section;

(ii) Submit complete and accurate data to HHS or its designees that is necessary to complete the audit, in the format and manner specified by HHS, no later than 30 calendar days after the initial audit response deadline established by HHS at the entrance conference

described under paragraph (c)(1)(i) of this section for the applicable benefit year;

(iii) Respond to all audit notices, letters, and inquiries, including requests for supplemental or supporting information, as requested by HHS, no later than 15 calendar days after the date of the notice, letter, request, or inquiry; and

(iv) In circumstances in which an issuer cannot provide the requested data or response to HHS within the timeframes under paragraph (c)(2)(ii) or (iii) of this section, as applicable, the issuer may make a written request for an extension to HHS. The extension request must be submitted within the timeframe established under paragraph (c)(2)(ii) or (iii), as applicable, and must detail the reason for the extension request and the good cause in support of the request. If the extension is granted, the issuer must respond within the timeframe specified in HHS's notice granting the extension of time.

(3) *Preliminary audit findings.* HHS will share its preliminary audit findings with the issuer, who will then have 30 calendar days to respond to such findings in the format and manner specified by HHS.

(i) If the issuer does not dispute or otherwise respond to the preliminary findings, the audit findings will become final.

(ii) If the issuer responds and disputes the preliminary findings, HHS will review and consider such response and finalize the audit findings after such review.

(4) *Final audit findings.* If an audit results in the inclusion of a finding in the final audit report, the issuer must comply with the actions set forth in the final audit report in the manner and timeframe established by HHS, and the issuer must complete all of the following:

(i) Within 45 calendar days of the issuance of the final audit or compliance review report, provide a written corrective action plan to HHS for approval.

(ii) Implement that plan.

(iii) Provide to HHS written documentation of the corrective actions once taken.

(5) *Failure to comply with audit activities.* If an issuer fails to comply with the audit activities set forth in this section in the manner and timeframes specified by HHS:

(i) HHS will notify the issuer of payments received under this subpart that the issuer has not adequately substantiated; and

(ii) HHS will notify the issuer that HHS may recoup any payments identified in paragraph (c)(5)(i) of this section.

(6) *Circumstances requiring HHS enforcement.* If HHS determines that the State Exchange or State-based Exchange on the Federal platform is not enforcing or fails to substantially enforce the requirements of this subpart or § 156.50, then HHS may do so and may pursue the imposition of civil money penalties as specified in § 156.805 for noncompliance by QHP issuers participating in the State Exchange or State Exchange on the Federal platform.

SUBPART F—CONSUMER OPERATED AND ORIENTED PLAN PROGRAM *[Not included in this compilation.]*

SUBPART G—MINIMUM ESSENTIAL COVERAGE

§ 156.600 The definition of minimum essential coverage.

The term *minimum essential coverage* has the same meaning as provided in section 5000A(f) of the Code and its implementing regulations for purposes of this subpart.

§ 156.602 Other coverage that qualifies as minimum essential coverage.

The following types of coverage are designated by the Secretary as minimum essential coverage for purposes of section 5000A(f)(1)(E) of the Code:

(a) *Self-funded student health coverage.* * For coverage beginning after December 31, 2014, sponsors of self-funded student health coverage may apply to be recognized as minimum essential coverage pursuant to the process provided under 45 CFR 156.604.

[* First sentence omitted: not applicable to coverage beginning on or after January 1, 2015.]

(b) *Refugee Medical Assistance supported by the Administration for Children and Families.* Coverage under Refugee Medical Assistance, authorized under section 412(e)(7)(A) of The Immigration and Nationality Act, provides up to eight months of coverage to certain noncitizens who are considered Refugees, as defined in section 101(a)(42) of the Act.

(c) *Medicare advantage plans.* Coverage under the Medicare program pursuant to Part C of title XVIII of the Social Security Act, which provides Medicare Parts A and B benefits through a private insurer.

(d) *State high risk pool coverage.* A qualified high risk pool as defined by section 2744(c)(2) of the Public Health Service Act established on or before November 26, 2014 in any State.

(e) *Other coverage.* Other coverage that qualifies pursuant to § 156.604.

§ 156.604 Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart.

(a) The Secretary may recognize "other coverage" as minimum essential coverage provided HHS determines that the coverage meets the following substantive and procedural requirements:

(1) *Coverage requirements.* A plan must meet substantially all the requirements of title I of the Affordable Care Act pertaining to non-grandfathered, individual health insurance coverage.

(2) *Procedural requirements for recognition as minimum essential coverage.* To be considered for recognition as minimum essential coverage, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator must submit the following information to HHS:

(i) Identity of the plan sponsor and appropriate contact persons;

(ii) Basic information about the plan, including:

(A) Name of the organization sponsoring the plan;

(B) Name and title of the individual who is authorized to make, and makes, this certification on behalf of the organization;

(C) Address of the individual named above;

(D) Phone number of the individual named above;

(E) Number of enrollees;

(F) Eligibility criteria;

(G) Cost sharing requirements, including deductible and out-of-pocket maximum limit;

(H) Essential health benefits covered; and

(I) A certification by the appropriate individual, named pursuant to paragraph (a)(3)(ii)(b), that the organization substantially complies with the requirements of title I of the Affordable Care Act that apply to non-grandfathered plans in the individual market and any plan documentation or other information that demonstrate that the coverage substantially comply with these requirements.

(b) CMS will publish a list of types of coverage that the Secretary has recognized as minimum essential coverage pursuant to this provision.

(c) If at any time the Secretary determines that a type of coverage previously recognized as minimum essential coverage no longer meets the coverage requirements of paragraph (a)(1) of this section, the Secretary may revoke the recognition of such coverage.

(d) *Notice.* Once recognized as minimum essential coverage, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator must provide notice to all enrollees of its minimum essential coverage status and must comply with the information reporting requirements of section 6055 of the Internal Revenue Code and implementing regulations.

§ 156.606 HHS audit authority.

The Secretary may audit a plan or program recognized as minimum essential coverage under § 156.604 at any time to ensure compliance with the requirements of § 156.604(a).

SUBPART H—OVERSIGHT AND FINANCIAL INTEGRITY STANDARDS FOR ISSUERS OF QUALIFIED HEALTH PLANS IN FEDERALLY-FACILITATED EXCHANGES

§ 156.705 Maintenance of records for Federally-facilitated Exchanges.

(a) *General standard.* Issuers offering QHPs in a Federally-facilitated Exchange must maintain all documents and records (whether paper, electronic, or other media) and other evidence of accounting procedures and practices, necessary for HHS to do the following:

(1) Periodically audit financial records related to QHP issuers' participation in a Federally-facilitated Exchange, and evaluate the ability of QHP issuers to bear the risk of potential financial losses; and

(2) Conduct compliance reviews or otherwise monitor QHP issuers' compliance with all Exchange standards applicable to issuers offering QHPs in a federally-facilitated Exchange as listed in this part.

(b) *Records.* The records described in paragraph (a) of this section include the sources listed in § 155.1210(b)(2), (3), and (5) of this subchapter.

(c) *Record retention timeframe.* Issuers offering QHPs in a Federally-facilitated Exchange must maintain all records referenced in paragraph (a) of this section for 10 years.

(d) *Record availability.* Issuers offering QHPs in a Federally-facilitated Exchange must make all records in paragraph (a) of this section available to HHS, the OIG, the Comptroller General, or their designees, upon request.

§ 156.715 Compliance Reviews of QHP Issuers in Federally-facilitated Exchanges.

(a) *General standard.* Issuers offering QHPs in a Federally-facilitated Exchange may be subject to compliance reviews to ensure ongoing compliance with Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange.

(b) *Records.* In preparation for or in the course of the compliance review, a QHP issuer must make available for HHS to review the records of the QHP issuer that pertain to its activities within a Federally-facilitated Exchange. Such records may include, but are not limited to the following:

(1) The QHP issuer's books and contracts, including the QHP issuer's policy manuals and other QHP plan benefit information provided to the QHP issuer's enrollees;

(2) The QHP issuer's policies and procedures, protocols, standard operating procedures, or other similar manuals related to the QHP issuer's activities in a Federally-facilitated Exchange;

(3) Any other information reasonably necessary for HHS to—

(i) Evaluate the QHP issuer's compliance with QHP certification standards and other Exchange standards applicable to issuers offering QHPs in a Federally-facilitated Exchange;

(ii) Evaluate the QHP's performance, including its adherence to an effective compliance plan, within a Federally-facilitated Exchange;

(iii) Verify that the QHP issuer has performed the duties attested to as part of the QHP certification process; and

(iv) Assess the likelihood of fraud or abuse.

(c) *Interest of Qualified Individuals and Qualified Employers.* HHS's findings from the compliance reviews under this section may be in conjunction with other findings related to the QHP issuers' compliance with certification standards, used to confirm that permitting the issuer's QHPs to be available through a Federally-facilitated Exchange is in the interest of the qualified individuals and qualified employers as provided under § 155.1000(c)(2) of this subchapter.

(d) *Onsite and desk reviews.* The QHP issuer will make available, for the purposes listed in paragraph (c) of this section, its premises, physical facilities and equipment (including computer and other electronic systems), for HHS to conduct a compliance review as provided under this section.

(1) A compliance review under this section will be carried out as an onsite or desk review based on the specific circumstances.

(2) Unless otherwise specified, nothing in this section is intended to preempt Federal laws and regulations related to information privacy and security.

(e) *Compliance review timeframe.* A QHP issuer may be subject to a compliance review up to 10 years from the last day of that plan benefit year, or 10 years from the last day that the QHP certification is effective if the QHP is no longer available through a Federally-facilitated Exchange; provided, however, that if the 10 year review period falls during an ongoing compliance review, the review period would be extended until the compliance review is completed.

(f) *Failure to comply.* A QHP issuer that fails to comply with a compliance review under this section may be subject to enforcement remedies under subpart I of this part.

SUBPART I—ENFORCEMENT REMEDIES IN THE EXCHANGES

§ 156.800 Available remedies; Scope.

(a) *Kinds of sanctions.* HHS may impose the following types of sanctions on QHP issuers in an Exchange that are not in compliance with Exchange standards applicable to issuers offering QHPs in an Exchange:

(1) Civil money penalties as specified in § 156.805; and

(2) Decertification of a QHP offered by the non-compliant QHP issuer in a Federally-facilitated Exchange as described in § 156.810.

(b) *Scope.* Sanctions under subpart I are applicable for non-compliance with QHP issuer participation standards and other standards applicable to issuers offering QHPs in a Federally-facilitated Exchange. Sanctions under paragraph (a)(1) of this section are also applicable for non-compliance by QHP issuers participating in State Exchanges and State-based Exchanges on the Federal platform when HHS is responsible for enforcement of the requirements in subpart E of this part and 45 CFR 156.50.

(c) *Compliance standard.* For calendar years 2014 and 2015, sanctions under this subpart will not be imposed if the QHP issuer has made good faith efforts to comply with applicable requirements.

(d) *Information sharing.* HHS may consult and share information about QHP issuers with other Federal and State regulatory and enforcement entities to the extent that the consultation and information is necessary for purposes of State or Federal oversight and enforcement activities.

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

(a) *Grounds for imposing civil money penalties.* Civil money penalties may be imposed on an issuer in an Exchange if, based on credible evidence, HHS has reasonably determined that the issuer has engaged in one or more of the following actions:

(1) Misconduct in the Federally-facilitated Exchange or substantial noncompliance with the Exchange standards and requirements applicable to issuers offering QHPs in the Federally-facilitated Exchange, including but not limited to issuer standards and requirements under parts 153 and 156 of this subchapter;

(2) Limiting the QHP's enrollees' access to medically necessary items and services that are required to be covered as a condition of the QHP issuer's ongoing participation in the Federally-facilitated Exchange, if the limitation has adversely affected or has a substantial likelihood of adversely affecting one or more enrollees in the QHP offered by the QHP issuer;

(3) Imposing on enrollees premiums in excess of the monthly beneficiary premiums permitted by Federal standards applicable to QHP issuers participating in the Federally-facilitated Exchange;

(4) Engaging in any practice that would reasonably be expected to have the effect of denying or discouraging enrollment into a QHP offered by the issuer (except as permitted by this part) by qualified individuals whose medical condition or history indicates the potential for a future need for significant medical services or items;

(5) Intentionally or recklessly misrepresenting or falsifying information that it furnishes—

(i) To HHS or an Exchange; or

(ii) To an individual or entity upon which HHS relies to make its certifications or evaluations of the QHP issuer's ongoing compliance with Exchange standards applicable to issuers offering QHPs in the Federally-facilitated Exchange;

(6) Failure to remit user fees assessed under § 156.50(c); or

(7) Failure to comply with the cost-sharing reductions and advance payments of the premium tax credit standards of subpart E of this Part.

(b) *Factors in determining the amount of civil money penalties assessed.* In determining the amount of civil money penalties, HHS may take into account the following:

(1) The QHP issuer's previous or ongoing record of compliance;

(2) The level of the violation, as determined in part by—

(i) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread; and

(ii) The magnitude of financial and other impacts on enrollees and qualified individuals; and

(3) Aggravating or mitigating circumstances, or other such factors as justice may require, including complaints about the issuer with regard to the issuer's compliance with the medical loss ratio standards required by the Affordable Care Act and as codified by applicable regulations.

(c) *Maximum penalty.* The maximum amount of penalty imposed for each violation is $100 as adjusted annually under 45 C.F.R. part 102 for each day for each QHP issuer for each individual adversely affected by the QHP issuer's non-compliance; and where the number of individuals cannot be determined, HHS may estimate the number of individuals adversely affected by the violation.

(d) *Request for hearing.* (1) An issuer may appeal the assessment of a civil money penalty under this section by filing a request for hearing under an applicable administrative hearing process.

(2) If an issuer files a request for hearing under this paragraph (d), the assessment of a civil money penalty will not occur prior to the issuance of the final administrative decision in the appeal.

(e) *Failure to request a hearing.* (1) If the QHP issuer does not request a hearing within 30 days of the issuance of the notice described in paragraph (d)(1) of this section, HHS may assess the proposed civil money penalty.

(2) HHS will notify the issuer in writing of any penalty that has been assessed under this subpart and of the means by which the QHP issuer or

another responsible entity may satisfy the CMP assessment.

(3) The QHP issuer has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with the requirements of the applicable administrative hearing process unless the QHP issuer can show good cause, as determined under § 156.905(b), for failing to timely exercise its right to a hearing.

(f) *Circumstances requiring HHS enforcement in State Exchanges and State-based Exchanges on the Federal platform.* (1) HHS will enforce the requirements of subpart E of this part and 45 CFR 156.50 if a State Exchange or State-based Exchange on the Federal platform notifies HHS that it is not enforcing these requirements or if HHS makes a determination using the process set forth at 45 CFR 150.201, *et seq.* that a State Exchange or State-based Exchange on the Federal platform is failing to substantially enforce these requirements.

(2) If HHS is responsible under paragraph (f)(1) of this section for enforcement of the requirements set forth in subpart E of this part or 45 CFR 156.50, HHS may impose civil money penalties on an issuer in a State Exchange or State-based Exchange on the Federal platform, in accordance with the bases and process for imposing civil money penalties set forth in this section.

§ 156.806 Notice of non-compliance.

If HHS learns of a potential violation described in § 156.805 or if a State informs HHS of a potential violation, prior to imposing any CMPs, HHS must provide a written notice to the issuer, to include the following:

(a) Describe the potential violation.

(b) Provide 30 days from the date of the notice for the QHP issuer to respond and to provide additional information to refute an alleged violation.

(c) State that a civil money penalty may be assessed if the allegations are not, as determined by HHS, refuted.

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) *Bases for decertification.* A QHP may be decertified on one or more of the following grounds:

(1) The QHP issuer substantially fails to comply with the Federal laws and regulations applicable to QHP issuers participating in the Federally-facilitated Exchange;

(2) The QHP issuer substantially fails to comply with the standards related to the risk adjustment, reinsurance, or risk corridors programs under 45 CFR part 153, including providing HHS with valid risk adjustment, reinsurance or risk corridors data;

(3) The QHP issuer substantially fails to comply with the transparency and marketing standards in §§ 156.220 and 156.225;

(4) The QHP issuer substantially fails to comply with the standards regarding advance payments of the premium tax credit and cost-sharing in subpart E of this part;

(5) The QHP issuer is operating in the Federally-facilitated Exchange in a manner that hinders the efficient and effective administration of the Exchange;

(6) The QHP no longer meets the applicable standards set forth under subpart C of this part.

(7) Based on credible evidence, the QHP issuer has committed or participated in fraudulent or abusive activities, including submission of false or fraudulent data;

(8) The QHP issuer substantially fails to meet the requirements under § 156.230 related to network adequacy standards or, § 156.235 related to inclusion of essential community providers;

(9) The QHP issuer substantially fails to comply with the law and regulations related to internal claims and appeals and external review processes;

(10) The State recommends to HHS that the QHP should no longer be available in a Federally-facilitated Exchange;

(11) The QHP issuer substantially fails to comply with the privacy or security standards set forth in § 156.260;

(12) The QHP issuer substantially fails to meet the requirements related to the cases forwarded to QHP issuers under subpart K of this part;

(13) The QHP issuer substantially fails to meet the requirements related to the offering of a QHP under subpart M of this part;

(14) The QHP issuer offering the QHP is the subject of a pending, ongoing, or final State regulatory or enforcement action or determination that relates to the issuer offering QHPs in the Federally-facilitated Exchanges; or

(15) HHS reasonably believes that the QHP issuer lacks the financial viability to provide coverage under its QHPs until the end of the plan year.

(b) *State sanctions and determinations.* (1) *State sanctions.* HHS may consider regulatory or enforcement actions taken by a State against a QHP issuer as a factor in determining whether to decertify a QHP offered by that issuer.

(2) *State determinations.* HHS may decertify a QHP offered by an issuer in a Federally-facilitated Exchange based on a determination or action by a State as it relates to the issuer offering QHPs in a Federally-facilitated Exchange, including when a State places an issuer or its parent organization into receivership or when the State recommends to HHS that the QHP no longer be available in a Federally-facilitated Exchange.

(c) *Standard decertification process.* For decertification actions on grounds other than those described in paragraphs (a)(7), (8), or (9) of this section, HHS will provide written notices to the QHP issuer, enrollees in that QHP, and the State department of insurance in the State in which the QHP is being decertified. The written notice must include the following:

(1) The effective date of the decertification, which will be a date specified by HHS that is no earlier than 30 days after the date of issuance of the notice;

(2) The reason for the decertification, including the regulation or regulations that are the basis for the decertification;

(3) For the written notice to the QHP issuer, information about the effect of the decertification on the ability of the issuer to offer the QHP in the Federally-facilitated Exchange and must include information about the procedure for appealing the decertification by making a hearing request; and

(4) The written notice to the QHP enrollees must include information about the effect of the decertification on enrollment in the QHP and about the availability of a special enrollment period, as described in § 155.420 of this subchapter.

(d) *Expedited decertification process.* For decertification actions on grounds described in paragraphs (a)(6), (7), (8), or (9) of this section, HHS will provide written notice to the QHP issuer, enrollees, and the State department of insurance in the State in which the QHP is being decertified. The written notice must include the following:

(1) The effective date of the decertification, which will be a date specified by HHS; and

(2) The information required by paragraphs (c)(2) through (4) of this section.

(e) *Request for hearing.* An issuer may appeal the decertification of a QHP offered by that issuer under paragraph (c) or (d) of this section by filing a request for hearing under an applicable administrative hearing process.

(1) If an issuer files a request for hearing under this paragraph (e):

(i) If the decertification is under paragraph (b)(1) of this section, the decertification will not take effect prior to the issuance of the final administrative decision in the appeal, notwithstanding the effective date specified in paragraph (b)(1) of this section.

(ii) If the decertification is under paragraph (b)(2) of this section, the decertification will be effective on the date specified in the notice of decertification, but the certification of the QHP may be reinstated immediately upon

issuance of a final administrative decision that the QHP should not be decertified.

(2) [Reserved]

§ 156.815 Plan suppression.

(a) *Suppression* means temporarily making a QHP certified to be offered through the Federally-facilitated Exchange unavailable for enrollment through the Federally-facilitated Exchange.

(b) *Grounds for suppression.* A QHP may be suppressed as described in paragraph (a) of this section on one or more of the following grounds:

(1) The QHP issuer notifies HHS of its intent to withdraw the QHP from a Federally-facilitated Exchange when one of the exceptions to guaranteed renewability of coverage related to discontinuing a particular product or discontinuing all coverage under § 147.106(c) or (d) of this subchapter applies;

(2) Data submitted for the QHP is incomplete or inaccurate;

(3) The QHP is in the process of being decertified as described in § 156.810(c) or (d), or the QHP issuer is appealing a completed decertification as described in subpart J of this part;

(4) The QHP issuer offering the QHP is the subject of a pending, ongoing, or final State regulatory or enforcement action or determination that could affect the issuer's ability to enroll consumers or otherwise relates to the issuer offering QHPs in the Federally-facilitated Exchanges; or

(5) One of the exceptions to guaranteed availability of coverage related to special rules for network plans or financial capacity limits under § 147.104(c) or (d) of this subchapter applies.

(c) A multi-State plan as defined in § 155.1000(a) of this subchapter may be suppressed as described in paragraph (a) of this section if OPM notifies the Exchange that:

(1) OPM has found a compliance violation within the multi-State plan, or

(2) One of the grounds for suppression in paragraph (b) of this section exists for the multi-State plan.

SUBPART J—ADMINISTRATIVE REVIEW OF QHP ISSUER SANCTIONS IN FEDERALLY-FACILITATED EXCHANGES [*Not included in this compilation.*]

SUBPART K–CASES FORWARDED TO QUALIFIED HEALTH PLANS AND QUALIFIED HEALTH PLAN ISSUERS IN FEDERALLY-FACILITATED EXCHANGES

§ 156.1010 Standards.

(a) A case is a communication brought by a complainant that expresses dissatisfaction with a specific person or entity subject to State or Federal laws regulating insurance, concerning the person or entity's activities related to the offering of insurance, other than a communication with respect to an adverse benefit determination as defined in § 147.136(a)(2)(i) of this subchapter. Issues related to adverse benefit determinations are not addressed in this section and are subject to the provisions in § 147.136 of this subchapter governing internal claims appeals and external review. Issues related to eligibility determination processes and appeals are not addressed in this section and are subject to the provisions in Subpart F of Part 155.

(b) QHP issuers operating in a Federally-facilitated Exchange must investigate and resolve, as appropriate, cases from the complainant forwarded to the issuer by HHS. Cases received by a QHP issuer operating in a Federally-facilitated Exchange directly from a complainant or the complainant's authorized representative will be handled by the issuer through its internal customer service process.

(c) Cases may be forwarded to a QHP issuer operating in a Federally-facilitated Exchange through a casework tracking system developed by HHS or other means as determined by HHS.

(d) Cases received by a QHP issuer operating in a Federally-facilitated Exchange from HHS must be resolved within 15 calendar days of receipt of the case. Urgent cases as defined in paragraph (e) of this section that do not otherwise fall within the scope of § 147.136 of this subchapter must be resolved no later than 72 hours after receipt of the case. Where applicable State laws and regulations establish timeframes for case resolution that are stricter than the standards contained in this paragraph, QHP issuers operating in a Federally-facilitated Exchange must comply with such stricter laws and regulations.

(e) For cases received from HHS by a QHP issuer operating in a Federally-facilitated Exchange, an urgent case is one in which there is an immediate need for health services because the non-urgent standard could seriously jeopardize the enrollee's or potential enrollee's life, or health or ability to attain, maintain, or regain maximum function; or one in which the process for non-urgent cases would jeopardize the enrollee's or potential enrollee's ability enroll in a QHP through the Federally-facilitated Exchange.

(f) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange are required to notify complainants regarding the disposition of the as soon as possible upon resolution of the case, but in no event later than three (3) business days after the case is resolved.

(1) For the purposes of meeting the requirement in this paragraph (f), notification may be by verbal or written means as determined most appropriate by the QHP issuer.

(2) In instances when the initial notification of a case's disposition is not written, written notification must be provided to the consumer in a timely manner.

(g) For cases received from HHS, QHP issuers operating in a Federally-facilitated Exchange must use the casework tracking system developed by HHS, or other means as determined by HHS, to document the following:

(1) The date of resolution of a case received from HHS;

(2) A resolution summary of the case no later than seven (7) business days after resolution of the case. The record must include a clear and concise narrative explaining how the case was resolved including information about how and when the complainant was notified of the resolution; and

(3) For a case in which a State agency, including but not limited to a State department of insurance, conducts an investigation related to that case, any compliance issues identified by the State agency implicating the QHP or QHP issuer.

(h) Cases received by a QHP issuer operating in a Federally-facilitated Exchange from a State in which the issuer offers QHPs must be investigated and resolved according to applicable State laws and regulations. With respect to cases directly handled by the State, HHS or any other appropriate regulatory authority, QHP issuers operating in a Federally-facilitated Exchange must cooperate fully with the efforts of the State, HHS, or other regulatory authority to resolve the case.

SUBPART L—QUALITY STANDARDS

§ 156.1105 Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges.

(a) *Application for approval.* An enrollee satisfaction survey vendor must be approved by HHS, in a form and manner to be determined by HHS, to administer, on behalf of a QHP issuer, enrollee satisfaction surveys to QHP enrollees. HHS will approve enrollee satisfaction survey vendors on an annual basis, and each enrollee satisfaction survey vendor must submit an application for each year that approval is sought.

(b) *Standards.* To be approved by HHS, an enrollee satisfaction survey vendor must meet each of the following standards:

(1) Sign and submit an application form for approval in accordance with paragraph (a) of this section;

(2) Ensure, on an annual basis, that appropriate staff participate in enrollee satisfaction survey vendor training and successfully complete a post-training certification exercise as established by HHS;

(3) Ensure the accuracy of their data collection, calculation and submission processes and attest to HHS the veracity of the data and these processes;

(4) Sign and execute a standard HHS data use agreement, in a form and manner to be determined by HHS, that establishes protocols related to the disclosure, use, and reuse of HHS data;

(5) Adhere to the enrollee satisfaction survey protocols and technical specifications in a manner and form required by HHS;

(6) Develop and submit to HHS a quality assurance plan and any supporting documentation as determined to be relevant by HHS. The plan must describe in adequate detail the implementation of and compliance with all required protocols and technical specifications described in paragraph (b)(5) of this section;

(7) Adhere to privacy and security standards established and implemented under § 155.260 of this subchapter by the Exchange with which they are associated;

(8) Comply with all applicable State and Federal laws;

(9) Become a registered user of the enrollee satisfaction survey data warehouse to submit files to HHS on behalf of its authorized QHP contracts;

(10) Participate in and cooperate with HHS oversight for quality-related activities, including, but not limited to: review of the enrollee satisfaction survey vendor's quality assurance plan and other supporting documentation; analysis of the vendor's submitted data and sampling procedures; and site visits and conference calls; and,

(11) Comply with minimum business criteria as established by HHS.

(c) *Approved list.* A list of approved enrollee satisfaction survey vendors will be published on an HHS Web site.

(d) *Monitoring.* HHS will periodically monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved enrollee satisfaction survey vendor is non-compliant with the standards required in paragraph (b) of this section, the survey vendor may be removed from the approved list described in paragraph (c) of this section and/or the submitted survey results may be ineligible to be included for ESS results.

(e) *Appeals.* An enrollee satisfaction survey vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.

§ 156.1110 Establishment of patient safety standards for QHP issuers.

(a) *Patient safety standards.* A QHP issuer that contracts with a hospital with greater than 50 beds must verify that the hospital, as defined in section 1861(e) of the Act:

(1) For plan years beginning before January 1, 2017, is Medicare-certified or has been issued a Medicaid-only CMS Certification Number (CCN) and is subject to the Medicare Hospital Conditions of Participation requirements for—

(i) A quality assessment and performance improvement program as specified in 42 CFR 482.21; and

(ii) Discharge planning as specified in 42 CFR 482.43.

(2) For plan years beginning on or after January 1, 2017—

(i)(A) Utilizes a patient safety evaluation system as defined in 42 CFR 3.20; and

(B) Implements a mechanism for comprehensive person-centered hospital discharge to improve care coordination and health care quality for each patient; or

(ii) Implements an evidence-based initiative, to improve health care quality through the collection, management and analysis of patient safety events that reduces all cause preventable harm, prevents hospital readmission, or improves care coordination.

(3) A QHP issuer must ensure that each of its QHPs meets the patient safety standards in accordance with this section.

(b) *Documentation.* A QHP issuer must collect:

(1) For plan years beginning before January 1, 2017, the CCN from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(1) of this section; and

(2) For plan years beginning on or after January 1, 2017, information, from each of its contracted hospitals with greater than 50 beds, to demonstrate that those hospitals meet patient safety standards required in paragraph (a)(2) of this section.

(c) *Reporting.* (1) A QHP issuer must make available to the Exchange the documentation referenced in paragraph (b) of this section, upon request by the Exchange, in a time and manner specified by the Exchange.

(2) Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the documentation 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.

§ 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 quality ratings 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.

§ 156.1125 Enrollee satisfaction survey system.

(a) *General requirement.* A QHP issuer must contract with an HHS-approved enrollee satisfaction survey (ESS) vendor, as identified by § 156.1105, in order to administer the Enrollee Satisfaction Survey of the QHP's enrollees. A QHP 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.

§ 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.

SUBPART M—QUALIFIED HEALTH PLAN ISSUER RESPONSIBILITIES

§ 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.

§ 156.1215 Payment and collections processes.

(a) *Netting of payments and charges for 2014.* [Omitted: not applicable to plan years beginning on or after January 1, 2015.]

(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.

§ 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.* (1) If the CMS hearing officer upholds the reconsideration decision, the issuer may request review by the Administrator of CMS within 15 calendar days of the date of the CMS hearing officer's decision. The request for review must specify the findings or issues that the issuer challenges. HHS may submit for review by the Administrator a statement supporting the decision of the CMS hearing officer.

(2) The Administrator will review the CMS hearing officer's decision, the statements of the issuer and HHS, 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 must provide its case by clear and convincing evidence with respect to issues of fact. The Administrator will send the decision and the reasons for the decisions to the issuer.

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

§ 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.

§ 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]

§ 156.1250 Acceptance of certain third party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, and their downstream entities, must accept premium and cost-sharing payments for the QHPs from the following third-party entities from plan enrollees (in the case of a downstream entity, to the extent the entity routinely collects premiums or cost sharing):

(a) A Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(b) An Indian tribe, tribal organization, or urban Indian organization; and

(c) A local, State, or Federal government program, including a grantee directed by a government program to make payments on its behalf.

§ 156.1255 Renewal and re-enrollment notices.

A health insurance issuer that is renewing an enrollment group's coverage in an individual market QHP offered through the Exchange (including a renewal with modifications) in accordance with § 147.106 of this subchapter, or that is nonrenewing coverage offered through the Exchange and automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange in accordance with § 155.335 of this subchapter, must include the following information in the applicable notice described in § 147.106(b)(5), (c)(1), or (f)(1) of this subchapter:

(a) Premium and advance payment of the premium tax credit information sufficient to notify the enrollment group of its expected monthly premium payment under the renewed coverage, in a form and manner specified by the Exchange, provided that if the Exchange does not provide this information to enrollees and does not require issuers to provide this information to enrollees, consistent with this section, such information must be provided in a form and manner specified by HHS;

(b) An explanation of the requirement to report changes to the Exchange, as specified in § 155.335(e) of this subchapter, the timeframe and channels through which changes can be reported, and the implications of not reporting changes;

(c) For an enrollment group that includes an enrollee on whose behalf advance payments of the premium tax credit are being provided, an explanation of the reconciliation process for advance payments of the premium tax credit established in accordance with 26 CFR 1.36B–4; and

(d) For an enrollment group that includes an enrollee being provided cost-sharing reductions, but for whom no QHP under the product remains available for renewal at the silver level, an explanation that in accordance with § 155.305(g)(1)(ii) of this subchapter, cost-sharing reductions are only available to an individual who is not an Indian if he or she is enrolled in a silver level QHP.

§ 156.1256 Other notices.

As directed by a Federally-facilitated Exchange, a health insurance issuer that is offering QHP coverage through a Federally-facilitated Exchange or a State-based Exchange on the Federal platform must notify its enrollees of material plan or benefit display errors and the enrollees' eligibility for a special enrollment period, included in § 155.420(d)(12) of this subchapter, within 30 calendar days after being notified by a Federally-facilitated Exchange that the error has been fixed, if directed to do so by a Federally-facilitated Exchange.

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PART 157—EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

Authority: Title I of the Affordable Care Act, Sections 1311, 1312, 1321, 1411, 1412, Pub. L. 111–148, 124 Stat. 199.

SUBPART A—GENERAL PROVISIONS

§ 157.10 Basis and scope.

(a) *Basis.* This part is based on the following sections of title I of the Affordable Care:

(1) 1311. Affordable choices of health benefits plans.

(2) 1312. Consumer Choice.

(3) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.

(4) 1411. Procedures for determining eligibility for Exchange participation, advance payments of the premium tax credit and cost-sharing reductions, and individual responsibility exemptions.

(5) 1412. Advance determination and payment of the premium tax credit and cost-sharing reductions.

(b) *Scope.* This part establishes the requirements for employers in connection with the operation of Exchanges.

§ 157.20 Definitions.

The following definitions apply to this part, unless otherwise indicated:

Federally-facilitated SHOP has the meaning given to the term in § 155.20 of this subchapter.

Full-time employee has the meaning given to the term in § 155.20 of this subchapter.

Large employer has the meaning given to the term in § 155.20 of this subchapter.

Qualified employee has the meaning given to the term in § 155.20 of this subchapter.

Qualified employer has the meaning given to the term in § 155.20 of this subchapter.

Small employer has the meaning given to the term in § 155.20 of this subchapter.

SUBPART B—[RESERVED]

SUBPART C—STANDARDS FOR QUALIFIED EMPLOYERS

§ 157.200 Eligibility of qualified employers to participate in a SHOP.

(a) *General requirement.* Only a qualified employer may participate in the SHOP in accordance with § 155.710 of this subchapter.

(b) *Continuing participation for growing small employers.* A qualified employer may continue to participate in the SHOP if it ceases to be a small employer in accordance with § 155.710 of this subchapter.

(c) *Participation in multiple SHOPs.* A qualified employer may participate in multiple SHOPs in accordance with § 155.710 of this subchapter.

§ 157.205 Qualified employer participation process in a SHOP for plan years beginning prior to January 1, 2018.

(a) *General requirements.* When joining the SHOP, a qualified employer must comply with the requirements, processes, and timelines set forth by this part and must remain in compliance for the duration of the employer's participation in the SHOP.

(b) *Selecting QHPs.* During an election period, a qualified employer may make coverage in a QHP available through the SHOP in accordance with the processes developed by the SHOP in accordance with § 155.705 of this subchapter.

(c) *Information dissemination to employees.* A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.

(d) *Payment.* A qualified employer must submit any contribution towards the premiums of any qualified employee according to the standards and processes described in § 155.705 of this subchapter.

(e) *Employees hired outside of the initial or annual open enrollment period.* Qualified employers must provide employees hired outside of the initial or annual open enrollment period with:

(1) An enrollment period to seek coverage in a QHP in accordance with § 155.725(g) of this subchapter; and

(2) Information about the enrollment process in accordance with § 155.725 of this subchapter.

(f) *New employees and changes in employee eligibility.* Qualified employers participating in the SHOP must provide the SHOP with information about dependents or employees whose eligibility status for coverage purchased through the employer in the SHOP has changed, including:

(1) Newly eligible dependents and newly qualified employees. In a Federally-facilitated SHOP or in a State Exchange that uses the Federal platform for SHOP functions, a qualified employer must provide information about a newly qualified employee on or before the thirtieth day after the day that the employee becomes a newly qualified employee; and

(2) Loss of qualified employee status.

(g) *Annual employer election period.* Qualified employers must adhere to the annual employer election period to change their program participation for the next plan year described in § 155.725(c) of this subchapter.

(h) *Applicability date.* The provisions of this section apply for plan years beginning prior to January 1, 2018. Section 157.206 is applicable for plan years beginning on or after January 1, 2018.

§ 157.206 Qualified employer participation process in a SHOP for plan years beginning on or after January 1, 2018.

(a) *General requirements.* When joining the SHOP, a qualified employer must comply with the requirements, processes, and timelines set forth by this part and must remain in compliance for the duration of the employer's participation in the SHOP.

(b) *Selecting QHPs.* During an election period, a qualified employer may make coverage in a QHP available through the SHOP in accordance with the processes developed by the SHOP in accordance with § 155.706 of this subchapter.

(c) *Information dissemination to employees.* A qualified employer participating in the SHOP must disseminate information to its qualified employees about the process to enroll in a QHP through the SHOP.

(d) *Employees hired outside of the initial or annual open enrollment period.* Qualified employers must provide employees hired outside of the initial or annual open enrollment period with information about the enrollment process.

(e) *Participation in the SHOP and termination of coverage or enrollment through the SHOP.* (1) Changes affecting participation. Employers must submit a new single employer application to the SHOP or withdraw from participating in the SHOP if the employer makes a change that could end its eligibility under § 155.710 of this subchapter.

(2) If an employer receives a determination of ineligibility to participate in the SHOP or the SHOP terminates its eligibility to participate in the SHOP, unless the SHOP notifies the issuer or issuers of the determination of ineligibility or termination of eligibility, the employer must notify the issuer or issuers of QHPs in which their group members are enrolled in coverage of its ineligibility or termination of eligibility within 5 business days of the end of any applicable appeal process under § 155.741 of this subchapter, which could include when the time to file an appeal lapses without an appeal being filed, when the appeal is rejected or dismissed, or when the appeal process concludes with an adjudication by the appeals entity, as applicable.

(3) Employers must promptly notify the issuer or issuers of QHPs in which their group members are enrolled in coverage if it wishes to terminate coverage or enrollment through the SHOP, unless the SHOP notifies the issuer or issuers.

(f) *Applicability date.* The provisions of this section apply for plan years beginning on or after January 1, 2018.

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PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

Authority: 42 U.S.C. 300gg–18.

§ 158.101 Basis and scope.

(a) *Basis.* This Part implements section 2718 of the Public Health Service Act (PHS Act).

(b) *Scope.* Subpart A of this Part establishes the requirements for health insurance issuers ("issuers") offering group or individual health insurance coverage to report information concerning premium revenues and the use of such premium revenues for clinical services provided to enrollees, activities that improve health care quality, and all other non-claims costs. Subpart B describes how this information will be used to determine, with respect to each medical loss ratio (MLR) reporting year, whether the ratio of the amount of adjusted premium revenue expended by the issuer on permitted costs to the total amount of adjusted premium revenue (MLR) meets or exceeds the percentages established by section 2718(b)(1) of the PHS Act. Subpart B also addresses requirements for calculating any rebate amounts that may be due in the event an issuer does not meet the applicable MLR standard. Subpart C implements the provision of section 2718(b)(1)(A)(ii) of the PHS Act allowing the Secretary to adjust the MLR standard for the individual market in a State if requiring issuers to meet that standard may destabilize the individual market. Subparts D through F provide for enforcement of this part, including requirements for issuers to maintain records and civil monetary penalties that may be assessed against issuers who violate the requirements of this Part.

§ 158.102 Applicability.

General requirements. The requirements of this Part apply to issuers offering group or individual health insurance coverage, including a grandfathered health plan as defined in § 147.140 of this subpart.

§ 158.103 Definitions.

For the purposes of this part, the following definitions apply unless specified otherwise.

Blended rate means a single rate charged for health insurance coverage provided to a single employer through two or more of an issuer's affiliated companies for employees in one or more States.

Contract reserves means reserves that are established by an issuer which, due to the gross premium pricing structure at issue, account for the value of the future benefits that at any time exceeds the value of any appropriate future valuation of net premiums at that time. Contract reserves must not include premium deficiency reserves. Contract reserves must not include reserves for expected MLR rebates.

Direct paid claims means claim payments before ceded reinsurance and excluding assumed reinsurance except as otherwise provided in this Part.

Enrollee means an individual who is enrolled, within the meaning of § 144.103 of this title, in group health insurance coverage, or an individual who is covered by individual insurance coverage, at any time during an MLR reporting year.

Experience rating refund means the return of a portion of premiums pursuant to a retrospectively rated funding arrangement when the sum of incurred losses, retention and margin are less than earned premium.

Group conversion charges means the portion of earned premium allocated to providing the privilege for a certificate holder terminated from a group health plan to purchase individual health insurance without providing evidence of insurability.

Health Plan means health insurance coverage offered through either individual coverage or a group health plan.

Individual market has the meaning given the term in section 2791(e)(1) of the PHS Act and section 1304(a)(2) of the Affordable Care Act.

Large Employer has the meaning given the term in § 144.103 of this subchapter.

Large group market has the meaning given the term in section 2791(e)(3) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

MLR reporting year means a calendar year during which group or individual health insurance coverage is provided by an issuer.

Policyholder means any entity that has entered into a contract with an issuer to receive health insurance coverage as defined in section 2791(b) of the PHS Act.

Prescription drug rebates and other price concessions means all remuneration received by or on behalf of an issuer, including remuneration received by and on behalf of entities providing pharmacy benefit management services to the issuer, that decrease the costs of a prescription drug covered by the issuer, regardless from whom the remuneration is received (for example, pharmaceutical manufacturer, wholesaler, retail pharmacy, or vendor). Prescription drug rebates and other price concessions include discounts, charge backs or rebates, cash discounts, free goods contingent on a purchase agreement, up-front payments, coupons, goods in kind, free or reduced-price services, grants, or other price concessions or similar benefits to the extent the value of these items reduce costs for the issuer, and excluding bona fide service fees. Prescription drug rebates and other price concessions exclude any remuneration, coupons, or price concessions for which the full value is passed on to the enrollee. Bona fide service fees mean fees paid by a drug manufacturer to an entity providing pharmacy benefit management services to the issuer that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufacturer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

Situs of the contract means the jurisdiction in which the contract is issued or delivered as stated in the contract.

Small Employer has the meaning given the term in § 144.103 of this subchapter.

Small group market has the meaning in section 2791(e)(5) of the PHS Act and section 1304(a)(3) of the Affordable Care Act.

Student administrative health fee has the meaning given the term in § 147.145 of this subchapter.

Student health insurance coverage has the meaning given the term in § 147.145 of this subchapter.

Student market means the market for student health insurance coverage.

Subscriber refers to both the group market and the individual market. In the group market, subscriber means the individual, generally the employee, whose eligibility is the basis for the enrollment in the group health plan and who is responsible for the payment of premiums. In the individual market, subscriber means the individual who purchases an individual policy and who is responsible for the payment of premiums.

Unearned premium means that portion of the premium paid in the MLR reporting year that is intended to provide coverage during a period which extends beyond the MLR reporting year. *Unpaid Claim Reserves* means reserves and liabilities established to account for claims that were incurred during the MLR reporting year but had not been paid within 3 months of the end of the MLR reporting year.

SUBPART A—DISCLOSURE AND REPORTING

§ 158.110 Reporting requirements related to premiums and expenditures.

(a) *General requirements.* For each MLR reporting year, an issuer must submit to the Secretary a report which complies with the requirements of this part, concerning premium revenue and expenses related to the group and individual health insurance coverage that it issued. Reporting requirements of this part that apply to expenses incurred directly by the issuer also apply to expenses for functions outsourced to or services provided by other entities retained by the issuer.

(b) *Timing and form of report.* * Beginning with the 2014 MLR reporting year, the report for each MLR reporting year must be submitted to the Secretary by July 31 of the year following the end of an MLR reporting year, on a form and in the manner prescribed by the Secretary.

[* First sentence omitted: not applicable after 2013 MLR reporting year.]

(c) *Transfer of Business.* Issuers that purchase a line or block of business from another issuer during an MLR reporting year are responsible for submitting the information and reports required by this Part for the assumed business, including for that part of the MLR reporting year that was prior to the purchase.

§ 158.120 Aggregate reporting.

(a) *General requirements.* For purposes of submitting the report required in § 158.110 of this subpart, the issuer must submit a report for each State in which it is licensed to issue health insurance coverage that includes the experience of all policies issued in the State during the MLR reporting year covered by the report. The report must aggregate data for each entity licensed within a State, aggregated separately for the large group market, the small group market and the individual market. Experience with respect to each policy must be included on the report submitted with respect to the State where the contract was issued, except as specified in § 158.120(d) of this subpart.

(b) *Group Health Insurance Coverage in Multiple States.* Group coverage issued by a single issuer that covers employees in multiple States must be attributed to the applicable State based on the situs of the contract. Group coverage issued by multiple affiliated issuers that covers employees in multiple States must be attributed by each issuer to each State based on the situs of the contract.

(c) *Group Health Insurance Coverage With Dual Contracts.* Where a group health plan involves health insurance coverage obtained from two affiliated issuers, one providing in-network coverage only and the second providing out-of-network coverage only, solely for the purpose of providing a group health plan that offers both in-network and out-of-network benefits, experience may be treated as if it were all related to the contract provided by the in-network issuer. However, if the issuer chooses this method of aggregation, it must apply it for a minimum of 3 MLR reporting years.

(d) *Exceptions.* (1) For individual market business sold through an association or trust, the experience of the issuer must be included in the State report for the issue State of the certificate of coverage.

(2) For employer business issued through a group trust or multiple employer welfare association (MEWA), the experience of the issuer must be included in the State report for the State where the employer (if sold through a trust) or the MEWA (if the MEWA is the policyholder) has its principal place of business.

(3) An issuer with policies that have a total annual limit of $250,000 or less must report the experience from such policies separately from other policies.

(4) An issuer with group policies that provide coverage to employees, substantially all of whom are: Working outside their country of citizenship; working outside of their country of citizenship and outside the employer's country of domicile; or non-U.S. citizens working in their home country, must aggregate and report the experience from these policies on a national basis, separately for the large group market and small group market, and separately from other policies.

(5) An issuer in the student market must aggregate and report the experience from these policies on a national basis, separately from other policies.

§ 158.121 Newer experience.

If, for any aggregation as defined in

§ 158.120, 50 percent or more of the total earned premium for an MLR reporting year is attributable to policies newly issued in that MLR reporting year, then the experience of these policies may be excluded from the report required under § 158.110 for that same MLR reporting year. If an issuer chooses to defer reporting of newer business as provided in this section, then the excluded experience must be added to the experience reported in the following MLR reporting year.

§ 158.130 Premium revenue.

(a) *General requirements.* An issuer must report to the Secretary earned premium for each MLR reporting year. Earned premium means all monies paid by a policyholder or subscriber as a condition of receiving coverage from the issuer, including any fees or other contributions associated with the health plan.

(1) Earned premium is to be reported on a direct basis except as provided in paragraph (b) of this section.

(2) All earned premium for policies issued by one issuer and later assumed by another issuer must be reported by the assuming issuer for the entire MLR reporting year during which the policies were assumed and no earned premium for that MLR reporting year must be reported by the ceding issuer.

(3) Reinsured earned premium for a block of business that was subject to indemnity reinsurance and administrative agreements effective prior to March 23, 2010, for which the assuming entity is responsible for 100 percent of the ceding entity's financial risk and takes on all of the administration of the block, must be reported by the assuming issuer and must not be reported by the ceding issuer.

(b) *Adjustments.* Earned premium must include adjustments to:

(1) Account for assessments paid to or subsidies received from Federal and State high risk pools.

(2) Account for portions of premiums associated with group conversion charges.

(3) Account for any experience rating refunds incurred, excluding any rebate paid based upon an issuer's MLR.

(4) Account for unearned premium.

(5) Account for the net payments or receipts related to the risk adjustment, risk corridors (using an adjustment percentage, as described in § 153.500 of this subchapter, equal to zero percent), and reinsurance programs under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

§ 158.140 Reimbursement for clinical services provided to enrollees.

(a) *General requirements.* The report required in § 158.110 must include direct claims paid to or received by providers, including under capitation contracts with physicians, whose services are covered by the policy for clinical services or supplies covered by the policy. In addition, the report must include claim reserves associated with claims incurred during the MLR reporting year, the change in contract reserves, reserves for contingent benefits and the medical claim portion of lawsuits, and any incurred experience rating refunds. Reimbursement for clinical services, as defined in this section, is referred to as "incurred claims." All components of and adjustments to incurred claims, with the exception of contract reserves, must be calculated based on claims incurred only during the MLR reporting year and paid through March 31st of the following year. Contract reserves must be calculated as of December 31st of the applicable year.

(1) If there are any group conversion charges for a health plan, the conversion charges must be subtracted from the incurred claims for the aggregation that includes the conversion policies and this same amount must be added to the incurred claims for the aggregation that provides coverage that is intended to be replaced by the conversion policies. If an issuer transfers portions of earned premium associated with group conversion privileges between group and individual lines of business in its Annual Statement accounting, these amounts must be added to or subtracted from incurred claims.

(2) Incurred claims must include the current year's unpaid claims reserves, including claims reported in the process of adjustment, percentage withholds from payments made to contracted providers, claims that are recoverable for anticipated coordination of benefits (COB), and claim recoveries received as a result of subrogation.

(3) Incurred claims must include claims incurred but not reported based on past experience, and modified to reflect current conditions such as changes in exposure, claim frequency or severity.

(4) Incurred claims must include changes in other claims-related reserves.

(5) Incurred claims must include incurred experience rating refunds and exclude rebates paid as required by § 158.240 based upon prior MLR reporting year experience.

(b) *Adjustments to incurred claims.* (1) Adjustments that must be deducted from incurred claims:

(i)(A) For MLR reporting years before 2022, prescription drug rebates received by the issuer;

(B) Beginning with the 2022 MLR reporting year, prescription drug rebates and other price concessions received and retained by the issuer, and prescription drug rebates and other price concessions that are received and retained by an entity providing pharmacy benefit management services to the issuer and are associated with administering the issuer's prescription drug benefits.

(ii) Overpayment recoveries received from providers.

(iii) Cost-sharing reduction payments received by the issuer to the extent not reimbursed to the provider furnishing the item or service.

(2) Adjustments that must be included in incurred claims:

(i) Market stabilization payments or receipts by issuers that are directly tied to claims incurred and other claims based or census based assessments.

(ii) State subsidies based on a stop-loss payment methodology.

(iii) The amount of incentive and bonus payments made to providers that are tied to clearly-defined, objectively measurable, and well-documented clinical or quality improvement standards that apply to providers.

(iv) The amount of claims payments recovered through fraud reduction efforts not to exceed the amount of fraud reduction expenses.

(3) Adjustments that must not be included in incurred claims:

(i) Amounts paid to third party vendors for secondary network savings.

(ii) Amounts paid to third party vendors for network development, administrative fees, claims processing, and utilization management. For example, if an issuer contracts with a behavioral health, chiropractic network, or high technology radiology vendor, or a pharmacy benefit manager, and the vendor reimburses the provider at one amount but bills the issuer a higher amount to cover its network development, utilization management costs, and profits, then the amount that exceeds the reimbursement to the provider must not be included in incurred claims.

(iii) Amounts paid, including amounts paid to a provider, for professional or administrative services that do not represent compensation or reimbursement for covered services provided to an enrollee. For example, medical record copying costs, attorneys' fees, subrogation vendor fees, compensation to paraprofessionals, janitors, quality assurance analysts, administrative supervisors, secretaries to medical personnel and medical record clerks must not be included in incurred claims.

(iv) Amounts paid to a provider for services that do not represent reimbursement for covered services provided to an enrollee and are directly covered by a student administrative health fee.

(4) Adjustments that must be either included in or deducted from incurred claims:

(i) Payment to and from unsubsidized State programs designed to address distribution of health risks across issuers via charges to low risk issuers that are distributed to high risk issuers must be included in or deducted from incurred claims, as applicable.

(ii) Receipts related to the transitional reinsurance program and net payments or receipts related to the risk adjustment and risk corridors programs (calculated using an adjustment percentage, as described in § 153.500 of this subchapter, equal to zero percent) under sections 1341, 1342, and 1343 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, 18062, 18063.

(5) Other adjustments to incurred claims:

(i) Affiliated issuers that offer group coverage at a blended rate may choose whether to make an adjustment to each affiliate's incurred claims and activities to improve health care quality, to reflect the experience of the issuer with respect to the employer as a whole, according to an objective formula that must be defined by the issuer prior to January 1 of the MLR reporting year, so as to result in each affiliate having the same ratio of incurred claims to earned premium for that employer group for the MLR reporting year as the ratio of incurred claims to earned premium calculated for the employer group in the aggregate.

(ii) [Reserved]

§ 158.150 Activities that improve health care quality.

(a) *General requirements.* The report required in § 158.110 must include expenditures directly related to activities that improve health care quality, as such activities are described in this section.

(b) *Activity requirements.* Activities conducted by an issuer to improve quality must meet the following requirements:

(1) The activity must be designed to:

(i) Improve health quality.

(ii) Increase the likelihood of desired health outcomes in ways that are capable of being objectively measured and of producing verifiable results and achievements.

(iii) Be directed toward individual enrollees or incurred for the benefit of specified segments of enrollees or provide health improvements to the population beyond those enrolled in coverage as long as no additional costs are incurred due to the non-enrollees.

(iv) Be grounded in evidence-based medicine, widely accepted best clinical practice, or criteria issued by recognized professional medical associations, accreditation bodies, government agencies or other nationally recognized health care quality organizations.

(2) The activity must be primarily designed to:

(i) Improve health outcomes including increasing the likelihood of desired outcomes compared to a baseline and reduce health disparities among specified populations.

(A) Examples include the direct interaction of the issuer (including those services delegated by contract for which the issuer retains ultimate responsibility under the insurance policy), providers and the enrollee or the enrollee's representative (for example, face-to-face, telephonic, web-based interactions or other means of communication) to improve health outcomes, including activities such as:

(*1*) Effective case management, care coordination, chronic disease management, and medication and care compliance initiatives including through the use of the medical homes model as defined in section 3502 of the Affordable Care Act.

(*2*) Identifying and addressing ethnic, cultural or racial disparities in effectiveness of identified best clinical practices and evidence based medicine.

(*3*) Quality reporting and documentation of care in non-electronic format.

(*4*) Health information technology to support these activities.

(*5*)(*i*) For MLR reporting years before 2021, actual rewards, incentives, bonuses, and reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(*ii*) Beginning with the 2021 MLR reporting year, actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs) that are not already reflected in premiums or claims, to the extent permitted by section 2705 of the PHS Act;

(*6*) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD–10 as the standard medical data code set, implementing ICD–10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d-2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

(B) [Reserved]

(ii) Prevent hospital readmissions through a comprehensive program for hospital discharge. Examples include:

(A) Comprehensive discharge planning (for example, arranging and managing transitions from one setting to another, such as hospital discharge to home or to a rehabilitation center) in order to help assure appropriate care that will, in all likelihood, avoid readmission to the hospital;

(B) Patient-centered education and counseling.

(C) Personalized post-discharge reinforcement and counseling by an appropriate health care professional.

(D) Any quality reporting and related documentation in non-electronic form for activities to prevent hospital readmission.

(E) Health information technology to support these activities.

(iii) Improve patient safety, reduce medical errors, and lower infection and mortality rates.

(A) Examples of activities primarily designed to improve patient safety, reduce medical errors, and lower infection and mortality rates include:

(*1*) The appropriate identification and use of best clinical practices to avoid harm.

(*2*) Activities to identify and encourage evidence-based medicine in addressing independently identified and documented clinical errors or safety concerns.

(*3*) Activities to lower the risk of facility-acquired infections.

(*4*) Prospective prescription drug Utilization Review aimed at identifying potential adverse drug interactions.

(*5*) Any quality reporting and related documentation in non-electronic form for activities that improve patient safety and reduce medical errors.

(*6*) Health information technology to support these activities.

(B) [Reserved]

(iv) Implement, promote, and increase wellness and health activities:

(A) Examples of activities primarily designed to implement, promote, and increase wellness and health activities, include—

(*1*) Wellness assessments;

(*2*) Wellness/lifestyle coaching programs designed to achieve specific and measurable improvements;

(*3*) Coaching programs designed to educate individuals on clinically

effective methods for dealing with a specific chronic disease or condition;

(*4*) Public health education campaigns that are performed in conjunction with State or local health departments;

(*5*) Actual rewards, incentives, bonuses, reductions in copayments (excluding administration of such programs), that are not already reflected in premiums or claims should be allowed as a quality improvement activity for the group market to the extent permitted by section 2705 of the PHS Act;

(*6*) Any quality reporting and related documentation in non-electronic form for wellness and health promotion activities;

(*7*) Coaching or education programs and health promotion activities designed to change member behavior and conditions (for example, smoking or obesity); and

(*8*) Health information technology to support these activities.

(B) [Reserved]

(v) Enhance the use of health care data to improve quality, transparency, and outcomes and support meaningful use of health information technology consistent with § 158.151 of this subpart.

(c) *Exclusions.* Expenditures and activities that must not be included in quality improving activities are:

(1) Those that are designed primarily to control or contain costs;

(2) The pro rata share of expenses that are for lines of business or products other than those being reported, including but not limited to, those that are for or benefit self-funded plans;

(3) Those which otherwise meet the definitions for quality improvement activities but which were paid for with grant money or other funding separate from premium revenue;

(4) Those activities that can be billed or allocated by a provider for care delivery and which are, therefore, reimbursed as clinical services;

(5) Establishing or maintaining a claims adjudication system, including costs directly related to upgrades in health information technology that are designed primarily or solely to improve claims payment capabilities or to meet regulatory requirements for processing claims, including maintenance of ICD–10 code sets adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended.

(6) That portion of the activities of health care professional hotlines that does not meet the definition of activities that improve health quality;

(7) All retrospective and concurrent utilization review;

(8) Fraud prevention activities;

(9) The cost of developing and executing provider contracts and fees associated with establishing or managing a provider network, including fees paid to a vendor for the same reason;

(10) Provider credentialing;

(11) Marketing expenses;

(12) Costs associated with calculating and administering individual enrollee or employee incentives;

(13) That portion of prospective utilization that does not meet the definition of activities that improve health quality; and

(14) Any function or activity not expressly included in paragraph (a) or (b) of this section, unless otherwise approved by and within the discretion of the Secretary, upon adequate showing by the issuer that the activity's costs support the definitions and purposes in this Part or otherwise support monitoring, measuring or reporting health care quality improvement.

§ 158.151 Expenditures related to Health Information Technology and meaningful use requirements.

(a) *General requirements.* An issuer may include as activities that improve health care quality such Health Information Technology (HIT) expenses as are required to accomplish the activities allowed in § 158.150 of this subpart and that are designed for use by health plans, health care providers, or enrollees for the electronic creation, maintenance, access, or exchange of health information, as well as those consistent with Medicare and/or Medicaid meaningful use requirements, and which may in whole or in part improve quality of care, or provide the technological infrastructure to enhance current quality improvement or make new quality improvement initiatives possible by doing one or more of the following:

(1) Making incentive payments to health care providers for the adoption of certified electronic health record technologies and their "meaningful use" as defined by HHS to the extent such payments are not included in reimbursement for clinical services as defined in § 158.140 of this subpart;

(2) Implementing systems to track and verify the adoption and meaningful use of certified electronic health records technologies by health care providers, including those not eligible for Medicare and Medicaid incentive payments;

(3) Providing technical assistance to support adoption and meaningful use of certified electronic health records technologies;

(4) Monitoring, measuring, or reporting clinical effectiveness including reporting and analysis of costs related to maintaining accreditation by nationally recognized accrediting organizations such as NCQA or URAC, or costs for public reporting of quality of care, including costs specifically required to make accurate determinations of defined measures (for example, CAHPS surveys or chart review of HEDIS measures and costs for public reporting mandated or encouraged by law.

(5) Tracking whether a specific class of medical interventions or a bundle of related services leads to better patient outcomes.

(6) Advancing the ability of enrollees, providers, issuers or other systems to communicate patient centered clinical or medical information rapidly, accurately and efficiently to determine patient status, avoid harmful drug interactions or direct appropriate care, which may include electronic Health Records accessible by enrollees and appropriate providers to monitor and document an individual patient's medical history and to support care management.

(7) Reformatting, transmitting or reporting data to national or international government-based health organizations for the purposes of identifying or treating specific conditions or controlling the spread of disease.

(8) Provision of electronic health records, patient portals, and tools to facilitate patient self-management.

(b) [Reserved]

§ 158.160 Other non-claims costs.

(a) *General requirements.* The report required in § 158.110 of this subpart must include non-claims costs described in paragraph (b) of this section and must provide an explanation of how premium revenue is used, other than to provide reimbursement for clinical services covered by the benefit plan, expenditures for activities that improve health care quality, and Federal and State taxes and licensing or regulatory fees as specified in this part.

(b) *Non-claims costs other than taxes and regulatory fees.* (1) The report required in § 158.110 of this subpart must include any expenses for administrative services that do not constitute adjustments to premium revenue as provided in § 158.130 of this subpart, reimbursement for clinical services to enrollees as defined in § 158.140 of this subpart, or expenditures on quality improvement activities as defined in §§ 158.150 and 158.151 of this subpart.

(2) Expenses for administrative services include the following:

(i) Cost-containment expenses not included as an expenditure related to an activity at § 158.150 of this subpart.

(ii) Loss adjustment expenses not classified as a cost containment expense.

(iii) Direct sales salaries, workforce salaries and benefits.

(iv) Agents and brokers fees and commissions.

(v) General and administrative expenses.

(vi) Community benefit expenditures.

(vii) Beginning with the 2022 MLR reporting year, prescription drug rebates and other price concessions that are received and retained by an entity providing pharmacy benefit management services to the issuer and are associated with administering the issuer's prescription drug benefits.

§ 158.161 Reporting of Federal and State licensing and regulatory fees.

(a) *Licensing and regulatory fees included.* The report required in § 158.110 must include statutory assessments to defray operating expenses of any State or Federal department, transitional reinsurance contributions assessed under section 1341 of the Patient Protection and Affordable Care Act, 42 U.S.C. 18061, and examination fees in lieu of premium taxes as specified by State law.

(b) *Licensing and regulatory fees excluded.* The report required in § 158.110 must include fines and penalties of regulatory authorities, and fees for examinations by any State or Federal departments other than as specified in § 158.161(a) as other non-claims costs, but not as an adjustment to premium revenue.

§ 158.162 Reporting of Federal and State taxes.

(a) *Federal taxes.* The report required in § 158.110 of this subpart must separately report:

(1) Federal taxes excluded from premium under subpart B which include all Federal taxes and assessments allocated to health insurance coverage reported under section 2718 of the PHS Act.

(2) Federal taxes not excluded from premium under subpart B of this part which include Federal income taxes on investment income and capital gains, as well as Federal employment taxes, as other non-claims costs.

(b) *State taxes and assessments.* The report required in § 158.110 of this subpart must separately report:

(1) State taxes and assessments excluded from premium under subpart B which include:

(i) Any industry-wide (or subset) assessments (other than surcharges on specific claims) paid to the State directly, or premium subsidies that are designed to cover the costs of providing indigent care or other access to health care throughout the State.

(ii) Guaranty fund assessments.

(iii) Assessments of State industrial boards or other boards for operating expenses or for benefits to sick employed persons in connection with disability benefit laws or similar taxes levied by States.

(iv) Advertising required by law, regulation or ruling, except advertising associated with investments.

(v) State income, excise, and business taxes other than premium taxes.

(vi) State premium taxes plus State taxes based on policy reserves, if in lieu of premium taxes.

(vii) Payments made by a Federal income tax exempt issuer for community benefit expenditures as defined in paragraph (c) of this section, limited to the highest of either:

(A) Three percent of earned premium; or

(B) The highest premium tax rate in the State for which the report is being submitted, multiplied by the issuer's earned premium in the applicable State market.

(viii) In lieu of reporting amounts described in paragraph (b)(1)(vi) of this section, an issuer

that is not exempt from Federal income tax may choose to report payment for community benefit expenditures as described in paragraph (c) of this section, limited to the highest premium tax rate in the State for which the report is being submitted multiplied by the issuer's earned premium in the applicable State market.

(2) State taxes and assessments not excluded from premium under subpart B which include:

(i) State sales taxes if the issuer does not exercise options of including such taxes with the cost of goods and services purchased.

(ii) Any portion of commissions or allowances on reinsurance assumed that represent specific reimbursement of premium taxes.

(iii) Any portion of commissions or allowances on reinsurance ceded that represents specific reimbursement of premium taxes.

(iv) State employment and similar taxes and assessments.

(c) *Community benefit expenditures.* Community benefit expenditures means expenditures for activities or programs that seek to achieve the objectives of improving access to health services, enhancing public health and relief of government burden. This includes any of the following activities that:

(1) Are available broadly to the public and serve low-income consumers;

(2) Reduce geographic, financial, or cultural barriers to accessing health services, and if ceased to exist would result in access problems (for example, longer wait times or increased travel distances);

(3) Address Federal, State or local public health priorities such as advancing health care knowledge through education or research that benefits the public;

(4) Leverage or enhance public health department activities such as childhood immunization efforts; and

(5) Otherwise would become the responsibility of government or another tax-exempt organization.

§ 158.170 Allocation of expenses.

(a) *General requirements.* Each expense must be reported under only one type of expense, unless a portion of the expense fits under the definition of or criteria for one type of expense and the remainder fits into a different type of expense, in which case the expense must be pro-rated between types of expenses. Expenditures that benefit lines of business or products other than those being reported, including but not limited to those that are for or benefit self-funded plans, must be reported on a pro rata share.

(b) Description of the methods used to allocate expenses. The report required in § 158.110 must include a detailed description of the methods used to allocate expenses, including incurred claims, quality improvement expenses, Federal and State taxes and licensing or regulatory fees, and other non-claims costs, to each health insurance market in each State. A detailed description of each expense element must be provided, including how each specific expense meets the criteria for the type of expense in which it is categorized, as well as the method by which it was aggregated.

(1) Allocation to each category should be based on a generally accepted accounting method that is expected to yield the most accurate results. Specific identification of an expense with an activity that is represented by one of the categories above will generally be the most accurate method. If a specific identification is not feasible, the issuer should provide an explanation of why it believes the more accurate result will be gained from allocation of expenses based upon pertinent factors or ratios such as studies of employee activities, salary ratios or similar analyses.

(2) Many entities operate within a group where personnel and facilities are shared. Shared expenses, including expenses under the terms of a management contract, must be apportioned pro rata to the entities incurring the expense.

(3) Any basis adopted to apportion expenses must be that which is expected to yield the most accurate results and may result from special studies of employee activities, salary ratios,

premium ratios or similar analyses. Expenses that relate solely to the operations of a reporting entity, such as personnel costs associated with the adjusting and paying of claims, must be borne solely by the reporting entity and are not to be apportioned to other entities within a group.

(c) *Disclosure of allocation methods.* The issuer must identify in the report required in § 158.110 of this subpart the specific basis used to allocate expenses reported under this Part to States and, within States, to lines of business including the individual market, small group market, large group market, supplemental health insurance coverage, health insurance coverage offered to beneficiaries of public programs (such as Medicare and Medicaid), and group health plans as defined in § 145.103 of this chapter and administered by the issuer.

(d) *Maintenance of records.* The issuer must maintain and make available to the Secretary upon request the data used to allocate expenses reported under this Part together with all supporting information required to determine that the methods identified and reported as required under paragraph (b) of this section were accurately implemented in preparing the report required in § 158.110 of this subpart.

SUBPART B—CALCULATING AND PROVIDING THE REBATE

§ 158.210 Minimum medical loss ratio.

Subject to the provisions of § 158.211 of this subpart:

(a) *Large group market.* For all policies issued in the large group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 85 percent, as determined in accordance with this part.

(b) *Small group market.* For all policies issued in the small group market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this part.

(c) *Individual market.* For all policies issued in the individual market in a State during the MLR reporting year, an issuer must provide a rebate to enrollees if the issuer has an MLR of less than 80 percent, as determined in accordance with this Part.

(d) *Adjustment by the Secretary.* If the Secretary has adjusted the percentage that issuers in the individual market in a specific State must meet, then the adjusted percentage determined by the Secretary in accordance with § 158.301 of this part *et seq.* must be substituted for 80 percent in paragraph (c) of this section.

§ 158.211 Requirement in States with a higher medical loss ratio.

(a) *State option to set higher minimum loss ratio.* For coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than that set forth in § 158.210, the State's higher percentage must be substituted for the percentage stated in § 158.210. If a State requires the small group market and individual market to be merged and also sets a higher MLR standard for the merged market, the State's higher percentage must be substituted for the percentage stated in § 158.210 for both the small group and individual markets.

(b) *Considerations in setting a higher minimum loss ratio.* In adopting a higher minimum loss ratio than that set forth in § 158.210, a State must seek to ensure adequate participation by health insurance issuers, competition in the health insurance market in the State, and value for consumers so that premiums are used for clinical services and quality improvements.

§ 158.220 Aggregation of data in calculating an issuer's medical loss ratio.

(a) *Aggregation by State and by market.* In general, an issuer's MLR must be calculated separately for the large group market, small group market and individual market within each State. However, if a State requires the small group market and individual market to be merged, then the data reported separately under subpart A of this part for the small group and individual market in that State must be merged for purposes of calculating an issuer's MLR and any rebates owing.

(b) *Years of data to include in calculating MLR.* Subject to paragraphs (c) and (d) of this section, an issuer's MLR for an MLR reporting year is calculated according to the formula in § 158.221 of

this subpart and aggregating the data reported under this Part for the following 3-year period:

(1) The data for the MLR reporting year whose MLR is being calculated; and

(2) The data for the two prior MLR reporting years.

(c) *Requirements for MLR reporting years 2011 and 2012.* [Omitted: not applicable after 2012 MLR reporting year.]

(d) *Requirements for MLR reporting years 2013 and 2014 for the student market only.* [Omitted: not applicable after 2014 MLR reporting year.]

§ 158.221 Formula for calculating an issuer's medical loss ratio.

(a) *Medical loss ratio.* (1) An issuer's MLR is the ratio of the numerator, as defined in paragraph (b) of this section, to the denominator, as defined in paragraph (c) of this section, subject to the applicable credibility adjustment, if any, as provided in § 158.232 of this subpart.

(2) An issuer's MLR shall be rounded to three decimal places. For example, if an MLR is 0.7988, it shall be rounded to 0.799 or 79.9 percent. If an MLR is 0.8253 or 82.53 percent, it shall be rounded to 0.825 or 82.5 percent.

(b) *Numerator.* The numerator of an issuer's MLR for an MLR reporting year must be the issuer's incurred claims, as defined in § 158.140 of this part, plus the issuer's expenditures for activities that improve health care quality, as defined in § 158.150 and § 158.151 of this part, that are reported for the years specified in § 158.220 of this subpart.

(1)-(2) [Omitted: not applicable after 2013 MLR reporting year.]

(3) The numerator of the MLR for policies that are reported separately under § 158.120(d)(3) of this part must be the amount specified in paragraph (b) of this section, except that for the 2012 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.75, for the 2013 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.50, and for the 2014 MLR reporting year, the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 1.25.

(4) The numerator of the MLR for policies that are reported separately under § 158.120(d)(4) of this part must be the amount specified in paragraph (b) of this section, except that the total of the incurred claims and expenditures for activities that improve health care quality are then multiplied by a factor of 2.00.

(5) The numerator of the MLR for policies that are reported separately under § 158.120(d)(5) of this part must be the amount specified in paragraph (b) of this section, except that for the 2013 MLR reporting year the total of the incurred claims and expenditures for activities that improve health care quality is then multiplied by a factor of 1.15.

(6) The numerator of the MLR in the individual and small group markets in States that adopted the transitional policy outlined in the CMS letter dated November 14, 2013 must be the amount specified in paragraph (b) of this section, except that issuers that provided transitional coverage may multiply the total incurred claims and expenditures for activities that improve health care quality incurred in 2014 in the respective State and market by a factor of 1.0001.

(7) The numerator of the MLR in the individual and small group markets for issuers participating in the State and Federal Exchanges (sometimes referred to as "Marketplaces") must be the amount specified in paragraph (b) of this section, except that the total incurred claims and expenditures for activities that improve health care quality incurred in 2014 in the respective State and market may be multiplied by a factor of 1.0004.

(8) Beginning with the 2020 MLR reporting year, an issuer may include in the numerator of the MLR any shared savings payments the issuer has made to an enrollee as a result of the enrollee choosing to obtain health care from a lower-cost, higher-value provider.

(c) *Denominator.* The denominator of an issuer's MLR must equal the issuer's premium revenue, as defined in § 158.130, excluding the issuer's Federal and State taxes and licensing and regulatory fees, described in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts related to risk adjustment, risk corridors, and reinsurance, described in § 158.130(b)(5).

§ 158.230 Credibility adjustment.

(a) *General rule.* An issuer may add to the MLR calculated under § 158.221(a) of this subpart the credibility adjustment specified by § 158.232 of this section, if such MLR is based on partially credible experience as defined in paragraph (c)(2) of this section. An issuer may not apply the credibility adjustment if the issuer's experience is fully credible, as defined in paragraph (c)(1) of this section, or non-credible, as defined in paragraph (c)(3) of this section.

(b) *Life-years.* The credibility of an issuer's experience is based upon the number of life-years covered by the issuer. Life-years means the total number of months of coverage for enrollees whose premiums and claims experience is included in the report to the Secretary required by § 158.110 of this part, divided by 12.

(c) *Credible experience.* (1) An MLR calculated under § 158.221(a) through (c) of this subpart is fully credible if it is based on the experience of 75,000 or more life-years.

(2) An MLR calculated under § 158.221(a) through (c) of this subpart is partially credible if it is based on the experience of at least 1,000 life-years and fewer than 75,000 life-years.

(3) An MLR calculated under § 158.221(a) through (c) of this subpart is non-credible if it is based on the experience of less than 1,000 life-years.

(d) If an issuer's MLR is non-credible, it is presumed to meet or exceed the minimum percentage required by § 158.210 or § 158.211 of this subpart.

§ 158.231 Life-years used to determine credible experience.

(a) The life-years used to determine the credibility of an issuer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years. If a State requires the small group market and individual market to be merged, then life-years used to determine credibility must be the life-years from the small group market and the individual market for the MLR reporting year plus the life-years from the small group market and the individual market for the two prior MLR reporting years.

(b) – (e) [Omitted: not applicable after 2014 MLR reporting year.]

§ 158.232 Calculating the credibility adjustment.

(a) *Formula.* An issuer's credibility adjustment, if any, is the product of the base credibility factor, as determined under paragraph (b) of this section, multiplied by the deductible factor, as determined under paragraph (c) of this section.

(b) *Base credibility factor.* (1) The base credibility factor for fully credible experience or for non-credible experience is zero.

(2) The base credibility factor for partially credible experience is determined based on the number of life-years included in the aggregation, as determined under § 158.231 of this subpart, and the factors shown in Table 1. When the number of life-years used to determine credibility exactly matches a life-year category listed in Table 1, the value associated with that number of life-years is the base credibility factor. The base credibility factor for a number of life-years between the values shown in Table 1 is determined by linear interpolation.

TABLE 1 TO § 158.232:
BASE CREDIBILITY FACTORS

Life-years	Base credibility factor
< 1,000	No Credibility.
1,000	8.3%.
2,500	5.2%.
5,000	3.7%.
10,000	2.6%.
25,000	1.6%.
50,000	1.2%.
≥ 75,000	0.0% (Full Credibility).

TABLE 2 TO § 158.232:
DEDUCTIBLE FACTOR

Health plan deductible	Deductible factor
<$2,500	1.000
$2,500	1.164
$5,000	1.402
≥ $10,000	1.736

(c) *Deductible factor*. (1) The deductible factor is based on the average per person deductible of policies whose experience is included in the aggregation, as determined under § 158.231 of this subpart. When the weighted average deductible, as determined in accordance with this section, exactly matches a deductible category listed in Table 2, the value associated with that deductible is the deductible factor. The deductible factor for an average weighted deductible between the values shown in Table 2 is determined by linear interpolation.

(i) The per person deductible for a policy that covers a subscriber and the subscriber's dependents shall be the lesser of: the deductible applicable to each of the individual family members; or the overall family deductible for the subscriber and subscriber's family divided by two (regardless of the total number of individuals covered through the subscriber).

(ii) The average deductible for an aggregation is calculated weighted by the life-years of experience for each deductible level of policies included in the aggregation.

(2) An issuer may choose to use a deductible factor of 1.0 in lieu of calculating a deductible factor based on the average of policies included in the aggregation.

(d) *No credibility adjustment.* Beginning with the 2013 MLR reporting year, the credibility adjustment for an MLR based on partially credible experience is zero if both of the following conditions are met:

(1) Each year in the aggregation included experience of at least 1,000 life-years; and

(2) The issuer's preliminary MLR, as defined under paragraph (f) of this section, for each year in the aggregation was below the applicable MLR standard, as established under §§ 158.210 and 158.211.

(e) *No credibility adjustment.* Beginning with the 2015 MLR reporting year for the student market only, the credibility adjustment for an MLR based on partially credible experience is zero if both of the following conditions are met:

(1) Each year in the aggregation included experience of at least 1,000 life-years; and

(2) The issuer's preliminary MLR, as defined under paragraph (f) of this section, for each year in the aggregation was below the applicable MLR standard, as established under §§ 158.210 and 158.211.

(f) *Preliminary MLR.* Preliminary MLR means the ratio of the numerator, as defined in § 158.221(b) and calculated as of March 31st of the year following the year for which the MLR report required in § 158.110 is being submitted, to the denominator, as defined in § 158.221(c), calculated using only a single year of experience, and without applying any credibility adjustment.

§ 158.240 Rebating premium if the applicable medical loss ratio standard is not met.

(a) *General requirement.* For each MLR reporting year, an issuer must provide a rebate to each enrollee if the issuer's MLR does not meet or exceed the minimum percentage required by §§ 158.210 and 158.211 of this subpart.

(b) *Definition of enrollee for purposes of rebate.* For the sole purpose of determining whom is entitled to receive a rebate pursuant to this part, the term "enrollee" means the subscriber, policyholder, and/or government entity that paid the premium for health care coverage received by an individual during the respective MLR reporting year.

(c) *Amount of rebate to each enrollee.* (1) For each MLR reporting year, an issuer must rebate to the enrollee, subject to paragraph (d) of this section, the total amount of premium revenue, as defined in § 158.130, received by the issuer from the enrollee, after subtracting Federal and State taxes and licensing and regulatory fees as provided in §§ 158.161(a) and 158.162(a)(1) and (b)(1), and after accounting for payments or receipts for risk adjustment, risk corridors, and reinsurance as provided in § 158.130(b)(5), multiplied by the difference between the MLR required by § 158.210 or § 158.211, and the issuer's MLR as calculated under § 158.221.

(2) For example, an issuer must rebate a pro rata portion of premium revenue if it does not meet an 80 percent MLR for the individual market in a State that has not set a higher MLR. If an issuer has a 75 percent MLR for the coverage it offers in the individual market in a State that has not set a higher MLR, the issuer must rebate 5 percent of the premium paid by or on behalf of the enrollee for the MLR reporting year after subtracting a pro rata portion of taxes and fees and accounting for payments or receipts related to the reinsurance, risk adjustment and risk corridors programs (calculated using an adjustment percentage, as described in § 153.500 of this subchapter, equal to zero percent). If the issuer's total earned premium for the MLR reporting year in the individual market in the State is $200,000, the issuer received transitional reinsurance payments of $2,500, and made net payments related to risk adjustment and risk corridors of $20,000 (calculated using an adjustment percentage, as described in § 153.500 of this subchapter, equal to zero percent), the issuer's gross earned premium in the individual market in the State would be $200,000 plus $2,500 minus $20,000, for a total of $182,500. If the issuer's Federal and State taxes and licensing and regulatory fees, including reinsurance contributions, that may be excluded from premium revenue as described in §§ 158.161(a), 158.162(a)(1) and 158.162(b)(1), allocated to the individual market in the State are $15,000, and the net payments related to risk adjustment and risk corridors, reduced by reinsurance receipts, that must be accounted for in premium revenue as described in §§ 158.130(b)(5), 158.221, and 158.240, are $17,500 ($20,000 reduced by $2,500), then the issuer would subtract $15,000 and add $17,500 to gross premium revenue of $182,500, for a base of $185,000 in premium. The issuer would owe rebates of 5 percent of $185,000, or $9,250 in the individual market in the State. In this example, if an enrollee of the issuer in the individual market in the State paid $2,000 in premiums for the MLR reporting year, or 1/100 of the issuer's total premium in that State market, then the enrollee would be entitled to 1/100 of the total rebates owed by the issuer, or $92.50.

(d) *Limitation on total rebate payable for each year in the aggregation.* For any State and market, an issuer may elect to limit the amount of rebate payable for the MLR reporting year to the issuer's total outstanding rebate liability with respect to all years included in the aggregation. If an issuer elects this option, the outstanding rebate liability with respect to a specific year in the aggregation must be calculated by multiplying the denominator with respect to that year, as defined in § 158.221(c), by the difference between the MLR required by § 158.210 or § 158.211 for the MLR reporting year, and the sum of the issuer's preliminary MLR for that year, as defined under § 158.232(f), and the credibility adjustment applicable to the current MLR reporting year. The outstanding rebate liability with respect to a specific year must be reduced by any rebate payments applied against it in prior MLR reporting years. A rebate paid for an MLR reporting year must be applied first to reduce the outstanding rebate liability with respect to the earliest year in the aggregation.

(e) *Timing of rebate.* * Beginning with the 2014 MLR reporting year, an issuer must provide any

rebate owing to an enrollee no later than September 30 following the end of the MLR reporting year.

[* First sentence omitted: not applicable after 2013 MLR reporting year.]

(f) *Late payment interest.* An issuer that fails to pay any rebate owing to an enrollee or subscriber in accordance with paragraph (e) of this section or to take other required action within the time periods set forth in this Part must, in addition to providing the required rebate to the enrollee, pay the enrollee interest at the current Federal Reserve Board lending rate or ten percent annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due under paragraph (e) of this section.

(g) *Rebate prepayment and safe harbor.* An issuer may choose to pay a portion or all of its estimated rebate amount for a given MLR reporting year to enrollees in any form specified in § 158.241 prior to the rebate payment deadlines set forth in §§ 158.240(e) and 158.241(a)(2) and in advance of submitting the MLR report required in § 158.110 to the Secretary. Issuers that choose to prepay a portion or all of their rebates must do so for all eligible enrollees in a given state and market in a non-discriminatory manner, and consistently with State law or other applicable state authority. If, after submitting the MLR report required in § 158.110, an issuer determines that its rebate prepayment amount in a given state and market is at least 95 percent, but less than 100 percent, of the total rebate amount owed for the applicable MLR reporting year to enrollees in that state and market, the issuer may, without penalty or late payment interest under paragraph (f) of this section, provide the remaining rebate amount to those enrollees no later than the rebate deadlines in §§ 158.240(e) and 158.241(a)(2) applicable to the following MLR reporting year. If the total rebate owed to an enrollee for the MLR reporting year is above the *de minimis* threshold established in § 158.243(a), the issuer cannot treat the remaining rebate owed to an enrollee after prepayment as *de minimis*, even if the remaining rebate is below the *de minimis* threshold.

§ 158.241 Form of rebate.

(a) *Current enrollees.* (1) An issuer may choose to provide any rebates owing to current enrollees in the form of a premium credit, lump-sum check, or, if an enrollee paid the premium using a credit card or direct debit, by lump-sum reimbursement to the account used to pay the premium.

(2) * Beginning with rebates due for the 2020 MLR reporting year, any rebate provided in the form of a premium credit must be provided by applying the full amount due to the monthly premium that is due no later than October 30 following the MLR reporting year. If the amount of the rebate exceeds the monthly premium, then any overage shall be applied to succeeding premium payments until the full amount of the rebate has been credited.

[* Language addressing earlier MLR reporting years omitted.]

(b) *Former enrollees in the individual market.* Rebates owing to former enrollees in the individual market must be paid in the form of lump-sum check or lump-sum reimbursement using the same method that was used for payment, such as credit card or direct debit.

§ 158.242 Recipients of rebates.

(a) *Individual market.* An issuer must meet its obligation to provide any rebate due to an enrollee in the individual market by providing it to the enrollee. For individual policies that cover more than one person, one lump-sum rebate may be provided to the subscriber on behalf of all enrollees covered by the policy.

(b) *Large group and small group markets.* Except as provided in paragraphs (b)(3) and (4) of this section, an issuer must meet its obligation to provide any rebate to persons covered under a group health plan by providing it to the policyholder.

(1) In the case of a policyholder that is a non-Federal governmental group health plan, the policyholder must use the amount of the rebate that is proportionate to the total amount of premium paid by all subscribers under the policy, for the benefit of subscribers in one of the following ways, at the option of the policyholder:

(i) For all subscribers covered under any option offered under the policyholder's group health plan at the time the rebate is received by the policyholder, to reduce the subscribers'

portion of premium for the subsequent policy year;

(ii) For subscribers covered, at the time the rebate is received by the policyholder, under the group health plan option for which the issuer is providing a rebate, to reduce the subscribers' portion of premium for the subsequent policy year;

(iii) A cash refund to subscribers of the group health plan option for which the issuer is providing a rebate, who were enrolled in the group health plan option either during the MLR reporting year that resulted in the issuer providing the rebate or at the time the rebate is received by the policyholder;

(iv) The reduction in future premium or the cash refund provided under paragraphs (b)(1)(i), (ii), or (iii) of this section may, at the option of the policyholder, be: Divided evenly among such subscribers; divided based on each subscriber's actual contributions to premium; or apportioned in a manner that reasonably reflects each subscriber's contributions to premium; and

(v) All rebate distributions made under paragraphs (b)(1)(i), (ii), or (iii) of this section must be made within 3 months of the policyholder's receipt of the rebate. Rebate distributions made after 3 months must include late payment interest at the current Federal Reserve Board lending rate or 10 percent annually, whichever is higher, on the total amount of the rebate, accruing from the date payment was due under this section.

(2) In the case of a policyholder that is a non-Federal governmental group health plan, the portion of a rebate based upon former subscribers' contributions to premium must be aggregated and used for the benefit of current subscribers in the group health plan in any manner permitted by paragraph (b)(1) of this section.

(3) If the policyholder is a group health plan that is not a governmental plan and not subject to the Employee Retirement Income Security Act of 1974, as amended (29 U.S.C. 1001 *et seq.*) (ERISA), rebates may only be paid to the policyholder if the issuer receives a written assurance from the policyholder that the rebates will be used as provided in paragraphs (b)(1) and (2) of this section; otherwise, the issuer must distribute the rebate directly to the subscribers of the group health plan covered by the policy during the MLR reporting year on which the rebate is based by dividing the entire rebate, including the amount proportionate to the amount of premium paid by the policyholder, in equal amounts to all subscribers entitled to a rebate without regard to how much each subscriber actually paid toward premiums.

(4) If the group health plan has been terminated at the time of rebate payment and the issuer cannot, despite reasonable efforts, locate the policyholder whose plan participants or employees were enrolled in the group health plan, the issuer must distribute the rebate directly to the subscribers of the terminated group health plan by dividing the entire rebate, including the amount proportionate to the amount of premium paid by the policyholder, in equal amounts to all subscribers entitled to a rebate without regard to how much each subscriber actually paid toward premiums.

§ 158.243 *De minimis* rebates.

(a) *Minimum threshold.* An issuer is not required to provide a rebate to an enrollee based upon the premium that enrollee paid, under the following circumstances:

(1) For a group policy for which the issuer distributes the rebate to the policyholder, if the total rebate owed to the policyholder and the subscribers combined is less than $20 for a given MLR reporting year; or for a group policy for which the issuer distributes the rebate directly to the subscribers, as provided in § 158.242(a)(3) and (4) of this subpart, if the total rebate owed to each subscriber is less than $5.

(2) In the individual market, if the total rebated owed to the subscriber is less than $5.

(b) *Distribution.* (1) An issuer must aggregate and distribute any rebates not provided because they did not meet the minimum threshold set forth in paragraph (a) of this section by aggregating the unpaid rebates by individual market, small group market and large group market in a State and use

them to increase the rebates provided to enrollees who receive rebates based upon the same MLR reporting year as the aggregated unpaid rebates. An issuer must distribute such aggregated rebates by providing additional premium credit or payment divided evenly among enrollees who are being provided a rebate.

(2) For example, an issuer in the individual market has aggregated unpaid rebates totaling $2,000, and the issuer has 10,000 enrollees who are entitled to be provided a rebate above the minimum threshold for the applicable MLR reporting year. The $2,000 must be redistributed to the 10,000 and added on to their existing rebate amounts. The $2,000 is divided evenly among the 10,000 enrollees, so the issuer increases each enrollee's rebate by $0.20.

§ 158.244 Unclaimed rebates.

An issuer must make a good faith effort to locate and deliver to an enrollee any rebate required under this Part. If, after making a good faith effort, an issuer is unable to locate a former enrollee, the issuer must comply with any applicable State law.

§ 158.250 Notice of rebates.

(a) *Notice of rebates to policyholders and subscribers of group health plans.* For each MLR reporting year, at the time any rebate of premium is provided to a policyholder of a group health plan in accordance with this part, an issuer must provide each policyholder who receives a rebate and subscribers whose policyholder receives a rebate, or each subscriber who receives a rebate directly from an issuer, the following information in a form prescribed by the Secretary:

(1) A general description of the concept of an MLR;

(2) The purpose of setting an MLR standard;

(3) The applicable MLR standard;

(4) The issuer's MLR, adjusted in accordance with the provisions of this subpart;

(5) The issuer's aggregate premium revenue as reported in accordance with § 158.130 of this part, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in § 158.162(a)(1) and (b)(1) of this part;

(6) The rebate percentage and the amount owed to enrollees, as defined in section 158.240(b), based upon the difference between the issuer's MLR and the applicable MLR standard; and

(7) The fact that, as provided by this subpart, the total aggregated rebate for the group health plan is being provided to the policyholder:

(i) If the policy provides benefits for a plan subject to ERISA, a statement that the policyholder may have additional obligations under ERISA's fiduciary responsibility provisions with respect to the handling of rebates and contact information for questions regarding the rebate;

(ii) If the policyholder is a non-Federal governmental plan, the proportion of the rebate attributable to subscribers' contribution to premium must be used for the benefit of subscribers, using one of the methods set forth in § 158.242(b)(1) of this subpart; and

(iii) If the policyholder is a group health plan that is not a governmental plan and is not subject to ERISA,

(A) The policyholder has provided written assurance that the proportion of the rebate attributable to subscribers' contribution to premium will be used for the benefit of current subscribers, using one of the methods set forth in § 158.242(b)(1) of this subpart, or

(B) If the policyholder did not provide such written assurance, the issuer must distribute the rebate evenly among the policyholder's subscribers covered by the policy during the MLR reporting year on which the rebate is based.

(b) *Notice of rebates to subscribers in the individual market.* For each MLR reporting year, at the time any rebate of premium is provided to a subscriber in the individual market in accordance with this part, an issuer must provide each subscriber that is receiving

the rebate the following information in a form prescribed by the Secretary:

(1) A general description of the concept of an MLR;

(2) The purpose of setting an MLR standard;

(3) The applicable MLR standard;

(4) The issuer's MLR, adjusted in accordance with the provisions of this subpart;

(5) The issuer's aggregate premium revenue as reported in accordance with § 158.130 of this part, minus any Federal and State taxes and licensing and regulatory fees that may be excluded from premium revenue as described in § 158.162(a)(1) and (b)(1) of this part; and

(6) The rebate percentage and amount owed to enrollees based upon the difference between the issuer's MLR and the applicable MLR standard.

§ 158.251 Notice of MLR information.

[*Not included—provision is not applicable after 2011 reporting year.*]

§ 158.260 Reporting of rebates.

(a) *General requirement.* For each MLR reporting year, an issuer must submit to the Secretary a report concerning the rebates provided to and on behalf of enrollees pursuant to this subpart.

(b) *Aggregation of information in the report.* The information in the report must be aggregated in the same manner as required by § 158.120.

(c) *Information to report.* The report required by this section must include the total:

(1) Number of subscribers in the individual, small group and large group markets to whom the issuer paid a rebate directly, and number of small group and large group policyholders receiving a rebate on behalf of enrollees;

(2) Amount of rebates provided as premium credit;

(3) Amount of rebates provided as lump sum payment regardless of whether in cash, reimbursement to an enrollee's credit card, or direct payment to an enrollee's bank account;

(4) Amount of rebates that were de minimis as provided in § 158.243 of this subpart and the number of enrollees who did not receive a rebate because it was de minimis; and

(5) Amount of unclaimed rebates, a description of the methods used to locate the applicable enrollees, and a description of how the unclaimed rebates were disbursed.

(d) *Timing and form of report.* The data required by paragraphs (c)(1) through (4) of this section must be submitted with the report under § 158.110, on a form and in the manner prescribed by the Secretary. The data required by paragraph (c)(5) of this section must be submitted with the report under § 158.110 for the subsequent MLR reporting year.

§ 158.270 Effect of rebate payments on solvency.

(a) If a State's insurance commissioner, superintendent, or other responsible official determines that the payment of rebates by a domestic issuer in that State will cause the issuer's risk based capital (RBC) level to fall below the Company Action Level RBC, as defined in the NAIC's Risk Based Capital (RBC) for Insurers Model Act, the commissioner, superintendent, or other responsible official must notify the Secretary. In such a circumstance, the commissioner, superintendent, or other responsible official may request that the Secretary defer all or a portion of the rebate payments owed by the issuer.

(b) In the event an insurance commissioner, superintendent, or other responsible official makes the request set forth in paragraph (a) of this section, the following should be provided to the Secretary along with the notification:

(1) The domestic issuer's RBC reports for the current calendar year and the 2 preceding calendar years; and

(2) A calculation of the amount of rebates that would be owed by the domestic issuer pursuant to this Part.

(c) Upon receipt of the notification under paragraph (a), the Secretary will examine the information provided by the insurance commissioner, superintendent, or other responsible official along with any other information the Secretary may request from the issuer, and determine whether the payment of rebates by the issuer will cause its RBC level to fall below the Company Action Level RBC.

(d) When the Secretary determines that the payment of rebates by an issuer will cause its RBC level to fall below the Company Action Level RBC, the Secretary may permit a deferral of all or a portion of the rebates owed, but only for a period determined by the Secretary in consultation with the State. The Secretary will require that the issuer must pay these rebates with interest in a future year in which payment of the rebates would not cause the issuer's RBC level to fall below the Company Action Level RBC.

SUBPART C—POTENTIAL ADJUSTMENT TO THE MLR FOR A STATE'S INDIVIDUAL MARKET

§ 158.301 Standard for adjustment to the medical loss ratio.

The Secretary may adjust the MLR standard that must be met by issuers offering coverage in the individual market in a State, as defined in section 2791 of the PHS Act, for a given MLR reporting year if, in the Secretary's discretion, the Secretary determines that there is a reasonable likelihood that an adjustment to the 80 percent MLR standard of section 2718(b)(1)(A)(ii) of the Public Health Service Act will help stabilize the individual market in that State.

§ 158.310 Who may request adjustment to the medical loss ratio.

A request for an adjustment to the MLR standard for a State must be submitted by the State's insurance commissioner, superintendent, or comparable official of that State in order to be considered by the Secretary.

§ 158.311 Duration of adjustment to the medical loss ratio.

A State may request that an adjustment to the MLR standard be for up to three MLR reporting years.

§ 158.320 Information supporting a request for adjustment to the medical loss ratio.

A State must submit in electronic format the information required by §§ 158.321 through 158.323 of this subpart in order for the request for adjustment to the MLR standard for the State to be considered by the Secretary. A State may submit to the Secretary any additional information it determines would support its request. In the event that certain data are unavailable or that the collection of certain data is unduly burdensome, a State may provide written notice to the Secretary and the Secretary may, at her discretion, request alternative supporting data or move forward with her determination.

§ 158.321 Information regarding the State's individual health insurance market.

(a) Subject to § 158.320, the State must provide, for each issuer who actively offers coverage in the individual market in the State, the following information, in accordance with paragraph (b) of this section, for the preceding calendar year and, at the State's option, for the current year:

(1) Total earned premium and incurred claims;

(2) Total number of enrollees (life-years and covered lives);

(3) Total agents' and brokers' commission expenses;

(4) Net underwriting gain;

(5) Risk-based capital level; and

(6) Whether the issuer has provided notice to the State's insurance commissioner, superintendent, or comparable State authority that the issuer will cease or begin offering individual market coverage on the Exchange, certain geographic areas, or the entire individual market in the State.

(b) The information required in paragraphs (a)(1) through (4) and (6) of this section must be provided

separately for the issuer's individual market plans grouped by the following categories, as applicable: On-Exchange, off-Exchange, grandfathered health plans as defined in § 147.140 of this subchapter, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage. The information required in paragraph (a)(5) of this section must be provided at the issuer level.

(c) The State must also provide information regarding whether any issuer other than those described in paragraph (a) of this section has provided notice to the State's insurance commissioner, superintendent, or comparable State authority that the issuer will cease or begin offering individual market coverage on the Exchange, certain geographic areas, or the entire individual market in the State.

§ 158.322 Proposal for adjusted medical loss ratio.

A State must provide its own proposal as to the adjustment it seeks to the MLR standard. This proposal must include an explanation of how an adjustment to the MLR standard for the State's individual market will help stabilize the State's individual market.

§ 158.323 State contact information.

A State must provide the name, telephone number, e-mail address, and mailing address of the person the Secretary may contact regarding the request for an adjustment to the MLR standard.

§ 158.330 Criteria for assessing request for adjustment to the medical loss ratio.

The Secretary may consider the following criteria in assessing whether an adjustment to the 80 percent MLR standard, as calculated in accordance with this subpart, would be reasonably likely to help stabilize the individual market in a State that has requested such adjustment:

(a) The number and financial performance (based on data provided by a State under § 158.321) of issuers actively offering individual health insurance coverage on- and off- Exchange, grandfathered health plans as defined in § 147.140 of this subchapter, coverage that meets the criteria for transitional policies outlined in applicable guidance, and non-grandfathered single risk pool coverage; the number of issuers reasonably likely to cease or begin offering individual market coverage in the State; and the likelihood that an adjustment to the 80 percent MLR standard could help increase competition in the individual market in the State, including in underserved areas.

(b) Whether an adjustment to the 80 percent MLR standard for the individual market may improve consumers' access to agents and brokers.

(c) The capacity of any new issuers or issuers remaining in the individual market to write additional business in the event one or more issuers were to cease offering individual market coverage on the Exchange, in certain geographic areas, or in the entire individual market in the State.

(d) The impact on premiums charged, and on benefits and cost sharing provided, to consumers by issuers remaining in or entering the individual market in the event one or more issuers were to cease or begin offering individual market coverage on the Exchange, in certain geographic areas, or in the entire individual market in the State.

(e) Any other relevant information submitted by the State's insurance commissioner, superintendent, or comparable official in the State's request.

§ 158.340 Process for submitting request for adjustment to the medical loss ratio.

(a) *Electronic submission.* A State must submit electronically, to an address and in a format prescribed by the Secretary, all of the information required by this subpart in order for its request for an adjustment to the MLR standard for its individual market to be considered by the Secretary.

(b) *Submission by mail.* A State may also submit by overnight delivery service or by U.S mail, return receipt requested, to an address and in a format prescribed by the Secretary, its request for an adjustment to the MLR standard for its individual market.

§ 158.341 Treatment as a public document.

A State's request for an adjustment to the MLR standard, and all information submitted as part of its request, will be treated as a public document. Instructions for how to access documents related to a State's request for an adjustment to the MLR

standard will be made available on the Secretary's website.

§ 158.342 Invitation for public comments.

The Secretary will invite public comment regarding a State's request for an adjustment to the MLR standard. All public comments must be submitted in writing within 10 days of the posting of the request, and must be submitted in the manner prescribed by the Secretary. The Secretary will consider timely public comments in assessing a State's request for an adjustment to the MLR standard.

§ 158.343 Optional State hearing.

Any State that submits a request for adjustment to the MLR standard may, at its option, hold a public hearing and create an evidentiary record with respect to its application. If a State does so, the Secretary will take the evidentiary record of the hearing into consideration in making her determination.

§ 158.344 Secretary's discretion to hold a hearing.

The Secretary may, at her discretion, conduct a public hearing with respect to a State's request for an adjustment to the MLR standard. All testimony and materials received in connection with any public hearing will be made part of the public record, and shall be considered by the Secretary in assessing a State's request for an adjustment to the MLR standard.

§ 158.345 Determination on a State's request for adjustment to the medical loss ratio.

(a) *General time frame.* The Secretary will make a determination as to whether to grant a State's request for an adjustment to the MLR standard within 30 days after determining that the information required by this subpart has been received.

(b) *Extension at the discretion of the Secretary.* The Secretary may, in her discretion, extend the 30 day time period in paragraph (a) of this section for as long a time as necessary not to exceed 30 days.

§ 158.346 Request for reconsideration.

(a) *Requesting reconsideration.* A State whose request for adjustment to the MLR standard has been denied by the Secretary may request reconsideration of that determination. A request for reconsideration must be submitted in writing to the Secretary within 10 days of her decision to deny the State's request for an adjustment, and may include any additional information in support of its request.

(b) *Reconsideration determination.* The Secretary will issue her determination on a State's request for reconsideration within 20 days of receiving the reconsideration request.

§ 158.350 Subsequent requests for adjustment to the medical loss ratio.

A State that has made a previous request for an adjustment to the MLR standard must, in addition to the other information required by this subpart, submit information as to what steps the State has taken since its prior requests, if any, to improve the stability of the State's individual market.

SUBPART D—HHS ENFORCEMENT

§ 158.401 HHS enforcement.

HHS enforces the reporting and rebate requirements described in subparts A and B, including but not limited to:

(a) The requirement that such reports be submitted timely.

(b) The requirement that the data reported complies with the definitions and criteria set forth in this part.

(c) The requirement that rebates be paid timely and accurately.

§ 158.402 Audits.

(a) *Notice of Audit.* HHS will provide 30 days advance notice of its intent to conduct an audit of an issuer.

(b) *Conferences.* All audits will include an entrance conference at which the scope of the audit will be presented and an exit conference at which the initial audit findings will be discussed.

(c) *Preliminary Audit Findings.* HHS will share its preliminary audit findings with the issuer, which will then have 30 days to respond to such findings. HHS may extend, for good cause, the time for an issuer to submit such a response.

(d) *Final Audit Findings.* If the issuer does not dispute the preliminary findings, the audit findings will become final. Alternatively, if the issuer responds to the preliminary findings, HHS will review and consider such response and finalize the audit findings.

(e) *Corrective actions.* HHS will send a copy of the final audit findings to the issuer as well as any corrective actions that issuer must undertake as a result of the audit findings.

(f) *Order to pay rebates.* If HHS determines as the result of an audit that an issuer has failed to pay rebates it is obligated to pay pursuant to this part, it may order the issuer to pay those rebates, together with interest from the date the rebates were due, in accordance with § 158.240(d) of this part.

§ 158.403 Circumstances in which a State is conducting audits of issuers.

(a) If a State conducts an audit of an issuer's MLR reporting and rebate obligations, HHS may, in the exercise of its discretion, accept the findings of that audit if HHS determines the following:

(1) The laws of the State permit public release of the findings of audits of issuers;

(2) The State's audit reports on the validity of the data regarding expenses and premiums that the issuer reported to the Secretary, including the appropriateness of the allocations of expenses used in such reporting and whether the activities associated with the issuer's reported expenditures for quality improving activities meet the definition of such activities;

(3) The State's audit reports on the accuracy of rebate calculations and the timeliness and accuracy of rebate payments;

(4) The State submits final audit reports to HHS within 30 days of finalization; and

(5) The State submits preliminary or draft audit reports to HHS within 6 months of the completion of audit field work unless they have already been finalized and reported under paragraph (a)(4) of this section.

(b) If HHS accepts an audit conducted by a State, and if the issuer makes additional rebate payments as a result of the audit, then HHS shall accept those payments as satisfying the issuer's obligation to pay rebates pursuant to this part.

SUBPART E—ADDITIONAL REQUIREMENTS ON ISSUERS

§ 158.501 Access to facilities and records.

(a) Each issuer subject to the reporting requirement of this part must allow access and entry to its premises, facilities and records, including computer and other electronic systems, to HHS, the Comptroller General, or their designees to evaluate, through inspection, audit, or other means, compliance with the requirements for reporting and calculation of data submitted to HHS, and the timeliness and accuracy of rebate payments made under this part.

(b) Each issuer must also allow access and entry to the facilities and records, including computer and other electronic systems, of its parent organization, subsidiaries, related entities, contractors, subcontractors, agents, or a transferee that pertain to any aspect of the data reported to HHS or to rebate payments calculated and made under this part. To the extent that the issuer does not control access to the facilities and records of its parent organization, related entities, or third parties, it will be the responsibility of the issuer to contractually obligate any such parent organization, related entities, or third parties to grant said access.

(c) The Comptroller General, HHS, or their designees may inspect, evaluate, and audit through 6 years from the date of the filing of a report required by this part or through 3 years after the completion of the audit and for such longer period set forth below provided that any of the following occur:

(1) HHS determines there is a special need to retain a particular record or group of records for a longer period and notifies the issuer at least 30 days before the disposition date.

(2) There has been a dispute, or allegation of fraud or similar fault by the issuer, in which case the retention may be extended to 6 years from the date of any resulting final resolution of the dispute, fraud, or similar fault.

(3) HHS determines that there is a reasonable possibility of fraud or similar fault, in which case HHS may inspect, evaluate, and audit the issuer at any time.

§ 158.502 Maintenance of records.

(a) *Basic rule.* Each issuer subject to the requirements of this part must maintain all documents and other evidence necessary to enable HHS to verify that the data required to be submitted in accordance with this part comply with the definitions and criteria set forth in this part, and that the MLR is calculated and any rebates owing are calculated and provided in accordance with this part. This includes but is not limited to all administrative and financial books and records used in compiling data reported and rebates provided under this part and in determining what data to report and rebates to provide under this part, electronically stored information, and evidence of accounting procedures and practices. This also includes all administrative and financial books and records used by others in assisting an issuer with its obligations under this part.

(b) *Length of time information must be maintained.* All of the documents and other evidence required by this part must be maintained for the current year and six prior years, unless a longer time is required under § 158.501 of this subpart.

SUBPART F—FEDERAL CIVIL PENALTIES

§ 158.601 General rule regarding the imposition of civil penalties.

If any issuer fails to comply with the requirements of this part, civil penalties, as described in this subpart, may be imposed.

§ 158.602 Basis for imposing civil penalties.

Civil penalties. For the violations listed in this paragraph, HHS may impose civil penalties in the amounts specified in § 158.606 of this subpart on any issuer who fails to do the following:

(a) Submit to HHS a report concerning the data required under this part by the deadline established by HHS.

(b) Submit to HHS a substantially complete or accurate report concerning the data required under this part.

(c) Timely and accurately pay rebates owing pursuant to this part.

(d) Respond to HHS inquiries as part of an investigation of issuer noncompliance.

(e) Maintain records as required under this part for the periodic auditing of books and records used in compiling data reported to HHS and in calculating and paying rebates pursuant to this Part.

(f) Allow access and entry to premises, facilities and records that pertain to any aspect of the data reported to HHS or to rebates calculated and paid pursuant to this part.

(g) Comply with corrective actions resulting from audit findings.

(h) Accurately and truthfully represent data, reports or other information that it furnishes to a State or HHS.

§ 158.603 Notice to responsible entities.

If HHS learns of a potential violation described in § 158.602 of this subpart or if a State informs HHS of a potential violation prior to imposing any civil monetary penalty HHS must provide written notice to the issuer, to include the following:

(a) Describe the potential violation.

(b) Provide 30 days from the date of the notice for the responsible entity to respond and to provide additional information to refute an alleged violation.

(c) State that a civil monetary penalty may be assessed if the allegations are not, as determined by HHS, refuted.

§ 158.604 Request for extension.

In circumstances in which an entity cannot prepare a response to HHS within the 30 days provided in the notice, the entity may make a written request for an extension from HHS detailing the reason for the extension request and showing good cause. If HHS grants the extension, the responsible entity must respond to the notice within the time frame specified in HHS's letter granting the extension of time. Failure to respond within 30 days, or within the extended time frame, may result in HHS's imposition of a civil monetary penalty based upon its determination of a potential violation described in § 158.602 of this subpart.

§ 158.605 Responses to allegations of noncompliance.

In determining whether to impose a civil monetary penalty, HHS may review and consider documentation provided in any complaint or other information, as well as any additional information provided by the responsible entity to demonstrate that it has complied with Affordable Care Act requirements. The following are examples of documentation that a potential responsible entity may submit for HHS's consideration in determining whether a civil monetary penalty should be assessed and the amount of any civil monetary penalty:

(a) Any evidence that refutes an alleged noncompliance.

(b) Evidence that the entity did not know, and exercising due diligence could not have known, of the violation.

(c) Evidence documenting the development and implementation of internal policies and procedures by an issuer to ensure compliance with the Affordable Care Act requirements regarding MLR. Those policies and procedures may include or consist of a voluntary compliance program. Any such program should do the following:

(1) Effectively articulate and demonstrate the fundamental mission of compliance and the issuer's commitment to the compliance process.

(2) Include the name of the individual in the organization responsible for compliance.

(3) Include an effective monitoring system to identify practices that do not comply with Affordable Care Act requirements regarding MLRs and to provide reasonable assurance that fraud, abuse, and systemic errors are detected in a timely manner.

(4) Address procedures to improve internal policies when noncompliant practices are identified.

(d) Evidence documenting the entity's record of previous compliance with Affordable Care Act requirements regarding MLRs.

§ 158.606 Amount of penalty—general.

A civil monetary penalty for each violation of § 158.602 of this subpart may not exceed $100 as adjusted annually under 45 C.F.R. part 102 for each day, for each responsible entity, for each individual affected by the violation. Penalties imposed under this Part are in addition to any other penalties prescribed or allowed by law.

§ 158.607 Factors HHS uses to determine the amount of penalty.

In determining the amount of any penalty, HHS may take into account the following:

(a) *The entity's previous record of compliance.* This may include any of the following:

(1) Any history of prior violations by the responsible entity, including whether, at any time before determination of the current violation(s), HHS or any State found the responsible entity liable for civil or administrative sanctions in connection with a violation of Affordable Care Act requirements regarding minimum loss ratios.

(2) Evidence that the responsible entity has never had a complaint for noncompliance with Affordable Care Act requirements regarding MLRs filed with a State or HHS.

(3) Such other factors as justice may require.

(b) *The gravity of the violation.* This may include any of the following:

(1) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread.

(2) The level of financial and other impacts on affected individuals.

(3) Other factors as justice may require.

§ 158.608 Determining the amount of the penalty—mitigating circumstances.

For every violation subject to a civil monetary penalty, if there are substantial or several mitigating circumstances, the aggregate amount of the penalty is set at an amount sufficiently below the maximum permitted by § 158.606 of this subpart to reflect that fact. As guidelines for taking into account the factors listed in § 158.607 of this subpart, HHS considers the following:

(a) *Record of prior compliance.* It should be considered a mitigating circumstance if the responsible entity has done any of the following:

(1) Before receipt of the notice issued under § 158.603 of this subpart, implemented and followed a compliance plan as described in § 158.605(c) of this subpart.

(2) Had no previous complaints against it for noncompliance.

(b) *Gravity of the violation(s).* It should be considered a mitigating circumstance if the responsible entity has done any of the following:

(1) Made adjustments to its business practices to come into compliance with the requirements of this Part so that the following occur:

(i) Each enrollee adversely affected by the violation has been paid any amount of rebate owed so that, to the extent practicable, that enrollee is in the same position that he, she, or it would have been in had the violation not occurred.

(ii) The rebate payments are completed in a timely manner.

(2) Discovered areas of noncompliance without notice from HHS and voluntarily reported that noncompliance, provided that the responsible entity submits the following:

(i) Documentation verifying that the rights and protections of all individuals adversely affected by the noncompliance have been restored; and

(ii) A plan of correction to prevent future similar violations.

(3) Demonstrated that the violation is an isolated occurrence.

(4) Demonstrated that the financial and other impacts on affected individuals is negligible or nonexistent.

(5) Demonstrated that the noncompliance is correctable and that a high percentage of the violations were corrected.

§ 158.609 Determining the amount of penalty—aggravating circumstances.

For every violation subject to a civil monetary penalty, if there are substantial or several aggravating circumstances, HHS may set the aggregate amount of the penalty at an amount sufficiently close to or at the maximum permitted by § 158.606 of this subpart to reflect that fact. HHS considers the following circumstances to be aggravating circumstances:

(a) The frequency of violation indicates a pattern of widespread occurrence.

(b) The violation(s) resulted in significant financial and other impacts on the average affected individual.

(c) The entity does not provide documentation showing that substantially all of the violations were corrected.

§ 158.610 Determining the amount of penalty—other matters as justice may require.

HHS may take into account other circumstances of an aggravating or mitigating nature if, in the interests of justice, they require either a reduction or an increase of the penalty in order to assure the achievement of the purposes of this Part, and if those circumstances relate to the entity's previous record of compliance or the gravity of the violation.

§ 158.611 Settlement authority.

Nothing in § 158.606 through § 158.610 of this subpart limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with § 158.603 of this subpart or to compromise on any penalty provided for in §§ 158.606 through 158.610 of this subpart.

§ 158.612 Limitations on penalties.

(a) *Circumstances under which a civil monetary penalty is not imposed.* HHS does not impose any civil monetary penalty on any failure for the period of time during which none of the responsible entities knew, or exercising reasonable diligence would have known, of the failure. HHS also may not impose a civil monetary penalty for the period of time after any of the responsible entities knew, or exercising reasonable diligence would have known of the failure, if the failure was due to reasonable cause and not due to willful neglect and the failure was corrected within 30 days of the first day that any of the entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the failure existed.

(b) *Burden of establishing knowledge.* The burden is on the responsible entity or entities to establish to HHS's satisfaction that no responsible entity knew, or exercising reasonable diligence would have known, that the failure existed.

§ 158.613 Notice of proposed penalty.

(a) *Contents of notice.* If HHS proposes to assess a penalty in accordance with this Part, it must provide the issuer written notice of its intent to assess a penalty, which includes the following:

(1) A description of the requirements under this Part that HHS has determined the issuer violated.

(2) A description of the information upon which HHS based its determination, including the basis for determining the number of affected individuals and the number of days or weeks for which the violations occurred.

(3) The amount of the proposed penalty as of the date of the notice.

(4) Any considerations described in § 158.607 through § 158.610 of this subpart that were taken into account in determining the amount of the proposed penalty.

(5) A specific statement of the issuer's right to a hearing.

(6) A statement that failure to request a hearing within 30 days after the date of the notice permits the assessment of the proposed penalty without right of appeal in accordance with § 158.615 of this subpart.

(b) *Delivery of Notice.* This notice must be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required.

§ 158.614 Appeal of proposed penalty.

Any issuer against which HHS has assessed a penalty under this Part may appeal that penalty in accordance with § 150.400 *et seq.*

§ 158.615 Failure to request a hearing.

If the issuer does not request a hearing within 30 days of the issuance of the notice described in § 158.613 of this subpart, HHS may assess the proposed civil monetary penalty indicated in such notice and may impose additional penalties as described in § 158.606 of this subpart. HHS must notify the issuer in writing of any penalty that has been assessed and of the means by which the issuer may satisfy the penalty. The issuer has no right to appeal a penalty with respect to which it has not requested a hearing in accordance with § 150.405 of this subchapter, unless the responsible entity can show good cause, as determined at § 150.405(b) of this subchapter, for failing to timely exercise its right to a hearing.