**DEPARTMENT OF HEALTH AND HUMAN SERVICES**

**45 CFR Parts 155, 156, and 157**

**[CMS-9989-F]**

**RIN 0938-AQ67**

**Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers**

**AGENCY:** Department of Health and Human Services.

**ACTION:** Final rule, Interim final rule.

**SUMMARY:** This final rule will implement the new Affordable Insurance Exchanges ("Exchanges"), consistent with title I of the Patient Protection and Affordable Care Act of 2010 as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing clout as large businesses.

**DATES:** Effective Date: These regulations are effective on [OFR: Insert date 60 days after the date of publication in the Federal Register]

Comment Date: Certain provisions of this final rule are being issued as interim final. We will consider comments from the public on the following provisions: §§ 155.220(a)(3); 155.300(b); 155.302; 155.305(g); 155.310(e); 155.315(g); 155.340(d); 155.345(a); and, 155.345(g). To be assured consideration, comments must be received at one of the addresses provided below, no

later than 5 p.m. Eastern Standard Time(EST) on [OFR: Insert date 45 days from date of publication in the Federal Register]

**ADDRESSES:** In commenting, please refer to file code CMS–9989–F. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission. You may submit comments in one of four ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to **http://www.regulations.gov**. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9989-F,

P.O. Box 8010,

Baltimore, MD 21244-8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9989-F,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

4. By hand or courier. If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Room 445-G, Hubert H. Humphrey Building,

200 Independence Avenue, SW.,

Washington, DC 20201

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD--

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786-9994 in advance to schedule your arrival with one of our staff members.

**FOR FURTHER INFORMATION CONTACT:**

Alissa DeBoy at (301) 492-4428 for general information and matters related to part 155.

Michelle Strollo at (301) 492-4429 for matters related to part 155 subparts D and E.

Pete Nakahata at (202) 680-9049 for matters related to part 156.

Rex Cowdry at (301) 492-4387 for matters related to part 155 subpart H and part 157.

**SUPPLEMENTARY INFORMATION:** *Inspection of Public Comments*: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following Web site as soon as possible after they have been received: http://regulations.gov. Follow the search instructions on that Web site to view public comments.

Comments received timely will be also available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

This final rule incorporates provisions originally published as two proposed rules, the July 15, 2011 rule titled Establishment of Exchanges and Qualified Health Plans ("Exchange establishment proposed rule"), and the August 17, 2011 rule titled Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers ("Exchange eligibility proposed rule"). These proposed rules are referred to collectively as the Exchange establishment and eligibility proposed rules. While originally published as separate rulemaking, the provisions contained in these proposed rules are integrally linked, and together encompass the key functions of Exchanges related to eligibility, enrollment, and plan participation and management. In addition, several sections in this final rule are being issued as interim final rules and we are soliciting comment on those sections. Given the highly connected

nature of these provisions, we are combining both proposed rules and the interim final rule into a single final rule for reader ease and consistency with the note that, even though the final rule is shorter than the sum of the two proposed rules, it is longer than each individually.

An updated Regulatory Impact Analysis associated with this final rule is available at http://cciio.cms.gov under "Regulations and Guidance." A summary of the aforementioned analysis is included as part of this final rule.

**Abbreviations**

Affordable Care Act - The Affordable Care Act of 2010 (which is the collective term for the Patient Protection and Affordable Care Act (Pub. L. 111-148) and the Health Care and Education Reconciliation Act (Pub. L. 111-152))

<EXTRACT>

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|---|---|
| BHP | Basic Health Program |
| CAHPS | Consumer Assessment of Healthcare Providers and Systems |
| CHIP | Children's Health Insurance Program |
| CMS | Centers for Medicare & Medicaid Services |
| DOL | U.S. Department of Labor |
| ERISA | Employee Retirement Income Security Act (29 U.S.C. section 1001, et seq.) |
| FEHBP | Federal Employees Health Benefits Program (5 U.S.C 8901, et seq.) |
| HEDIS | Healthcare Effectiveness Data and Information Set |
| HHS | U.S. Department of Health and Human Services |
| HIPAA | Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104-191) |
| HMO | Health Maintenance Organization |
| IHS | Indian Health Service |

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|---|---|
| IRS | Internal Revenue Service |
| LEP | Limited English Proficient |
| MAGI | Modified Adjusted Gross Income |
| MEWA | Multiple Employer Welfare Arrangement |
| NAIC | National Association of Insurance Commissioners |
| OMB | Office of Management and Budget |
| OPM | U.S. Office of Personnel Management |
| PBM | Pharmacy Benefit Manager |
| PHS Act | Public Health Service Act |
| PRA | Paperwork Reduction Act of 1985 |
| QHP | Qualified Health Plan |
| SHOP | Small Business Health Options Program |
| SSA | Social Security Administration |
| SSN | Social Security Number |
| The Act | Social Security Act |
| The Code | Internal Revenue Code of 1986 |
| TIN | Taxpayer Identification Number</EXTRACT> |

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Executive Summary: Beginning in 2014, individuals and small businesses will be able to purchase private health insurance through competitive marketplaces called Affordable Insurance Exchanges, or "Exchanges." Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs, and Exchanges will give individuals and small businesses the same purchasing clout as big businesses.

This final rule: (1) Sets forth the minimum Federal standards that States must meet if they elect to establish and operate an Exchange, including the standards related to individual and employer eligibility for and enrollment in the Exchange and insurance affordability programs; (2) outlines minimum standards that health insurance issuers must meet to participate in an Exchange and offer qualified health plans (QHPs); and (3) provides basic standards that employers must meet to participate in the Small Business Health Options Program (SHOP). The intent of this final rule is to afford States substantial discretion in the design and operation of an Exchange, with greater standardization provided where directed by the statute or where there are compelling practical, efficiency or consumer protection reasons. Consistent with the scope of the Exchange establishment and eligibility proposed rules, this final rule does not address all of the Exchange provisions in the Affordable Care Act; rather, more details will be provided in forthcoming guidance and future rulemaking, where appropriate.

A portion of this rule is issued on an interim final basis. As such, we will consider comments from the public on the following provisions:

- §155.220(a)(3) – Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.
- §155.300(b) – Related to Medicaid and CHIP regulations;
- §155.302 – Related to options for conducting eligibility determinations;
- §155.305(g) – Related to eligibility standards for cost-sharing reductions;
- §155.310(e) – Related to timeliness standards for Exchange eligibility determinations;
- §155.315(g) – Related to verification for applicants with special circumstances;
- §155.340(d) – Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions; and
- §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs.

## I. Background

### A. Legislative Overview

#### 1. Legislative Requirements for Establishing Exchanges

Section 1311(b) and section 1321(b) of the Affordable Care Act provide that each State has the opportunity to establish an Exchange(s) that: (1) Facilitates the purchase of insurance coverage by qualified individuals through qualified health plans (QHPs); (2) assists qualified employers in the enrollment of their employees in QHPs; and (3) meets other standards specified in the Affordable Care Act.

Section 1321 of the Affordable Care Act discusses State flexibility in the operation and enforcement of Exchanges and related policies. Section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary. Section 1311(d) describes the minimum functions of an Exchange, including the certification of QHPs.

Section 1321(c)(1) directs the Secretary to establish and operate such Exchange within States that either: (1) Do not elect to establish an Exchange, or (2) as determined by the Secretary on or before January 1, 2013, will not have an Exchange operable by January 1, 2014. Section 1321(a) also provides broad authority for the Secretary to establish standards and regulations to implement the statutory standards related to Exchanges, QHPs, and other components of title I of the Affordable Care Act.

Section 1401 of the Affordable Care Act creates new section 36B of the Internal Revenue Code (the Code), which provides for a premium tax credit for eligible individuals who enroll in a QHP through an Exchange. Section 1402 establishes provisions to reduce the cost-sharing obligation of certain eligible individuals enrolled in a QHP offered through an Exchange, including standards for determining Indians eligible for certain categories of cost-sharing reductions.

Under section 1411 of the Affordable Care Act, the Secretary is directed to establish a program for determining whether an individual meets the eligibility standards for Exchange participation, advance payments of the premium tax credit, cost-sharing reductions, and exemptions from the individual responsibility provision.

Sections 1412 and 1413 of the Affordable Care Act and section 1943 of the Social Security Act (the Act), as added by section 2201 of the Affordable Care Act, contain additional

provisions regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions, as well as provisions regarding simplification and coordination of eligibility determinations and enrollment with other health programs.

Unless otherwise specified, the provisions in this final rule related to the establishment of minimum functions of an Exchange are based on the general authority of the Secretary under section 1321(a)(1) of the Affordable Care Act.

<HD3>2. Legislative Requirements for Related Provisions

Subtitle K of title II of the Affordable Care Act, Protections for American Indians and Alaska Natives, section 2901, extends special benefits and protections to Indians including limits on cost sharing and payer of last resort requirements for health programs operated by the Indian Health Service (IHS), Indian tribes, tribal organizations, and urban Indian organizations. We are finalizing special Exchange enrollment periods and the reductions in cost sharing for Indians authorized, respectively, by sections 1311(c)(6) and 1402(d) of the Affordable Care Act under this authority in subparts D and E of part 155, and we expect to address others in future rulemaking.

Section 6005 of the Affordable Care Act creates new section 1150A of the Act, which directs QHP issuers, and sponsors of certain plans offered under part D of title XVIII of the Act to provide data on the cost and distribution of prescription drugs covered by the plan. We are codifying these standards under this authority in subpart C of part 156.

<HD2>B. Structure of the Final Rule

The regulations outlined in this final rule are codified in the new 45 CFR parts 155, 156, and 157. Part 155 outlines the standards relative to the establishment, operation, and minimum functionality of Exchanges, including eligibility standards for insurance affordability programs.

Part 156 outlines the standards for health insurance issuers with respect to participation in an Exchange, including the minimum certification standards for QHPs. Many provisions in part 155 have parallel provisions under part 156 because the Affordable Care Act creates complementary responsibilities for Exchanges and QHP issuers. Where possible, there are cross-references between parts 155 and 156 to avoid redundancy. Part 157 establishes the participation standards for employers in the Small Business Health Options Program (SHOP).

Subjects included in the Affordable Care Act to be addressed in separate rulemaking include but are not limited to: (1) Standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility policy and payment under section 1411(a)(4); (2) defining essential health benefits, actuarial value and other benefit design standards; and (3) standards for Exchanges and QHP issuers related to quality.

We note that the health plan standards set forth under this final rule are, for the most part, strictly related to QHPs certified to be offered through the Exchange and not the entire individual and small group market. Such policies for the entire individual and small and large group markets have been, and will continue to be, addressed in separate rulemaking issued by HHS, and the Departments of Labor and the Treasury.

<HD2>C. Alignment with Related Rules and Published Information

The Exchange eligibility proposed rule was published in conjunction with "Medicaid Program; Eligibility Changes under the Affordable Care Act of 2010 - CMS-2349-P," which will be referred to throughout this final rule as the "Medicaid proposed rule" and the proposed rule published by the Department of the Treasury, "Health Insurance Premium Tax Credits – REG 131491-10," which will be referred to throughout this final rule as the "Treasury proposed rule". This regulation includes numerous cross-references to the Medicaid final rule, which is expected

to be finalized shortly after this final rule. The Treasury final rule is expected to be published soon after this Exchanges final rule.

HHS published a document titled "State Exchange Implementation Question and Answers" on November 29, 2011[1]. We reference this document throughout the preamble where the information complements policies in this final rule.

## II. Provisions of the Proposed Regulation and Analysis and Responses to Public Comments

The Exchange establishment and eligibility proposed rules were published in the **Federal Register** on July 15, 2011 and August 17, 2011, respectively, with comment periods ending October 31, 2011. In total, we received approximately 24,781 comments on both proposed rules. Of the comments received, about 23,000 were a collection of letter campaigns related to women's services, or general public comments on the Affordable Care Act and the government's role in healthcare, but not specific to the proposed rules. We also received a number of comments on essential health benefits and preventive services. We have not addressed such comments, and others that are not directly related to the proposed rule, because they are outside the scope of this final rule.

Before the proposed rules, HHS also published a Request for Comment (the RFC) on August 3, 2010 (75 FR 45584) inviting the public to provide input regarding the rules that will govern the Exchanges. In this final rule, we have responded to comments submitted in response to the Exchange establishment and eligibility proposed rules and the RFC, where relevant. These comments are not separately identified, but instead are incorporated into each substantive section of the final rule as appropriate. For the most part, we address issues according to the numerical order of the regulation sections.

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[1] State Exchange Implementation Questions and Answers, published November 29, 2011: http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf.

Comments represented a wide variety of stakeholders, including but not limited to States, tribes, tribal organizations, health plans, consumer groups, healthcare providers, industry experts, and members of the public. In addition, we held consultation sessions on August 22, 2011, September 7, 2011, and September 15, 2011 to provide an overview of the proposed rule where Tribal governments were afforded an opportunity to ask questions and make comments. The public was reminded to submit written comments before the close of the public comment period that was announced in the proposed rule and we extended the comment period by 30 days to ensure ample opportunity for comments.

Many commenters addressed the balance between flexibility for States and Exchanges and standardization and predictability for consumers nationwide. Commenters also expressed concerns about differences between Exchange and Medicaid policies and about various aspects of the eligibility verification and redetermination process.

While we recognize that consumers may benefit from national standards, we continue to believe that States are best equipped to adapt the minimum Exchange functions to their local markets and the unique needs of their residents. Further, States already have significant experience performing many key functions, including oversight and enforcement of health plans, and determining eligibility for health benefit programs. Therefore, where possible we finalized provisions of the proposed rule that provided significant discretion for States to go beyond the minimum standards in implementing and designing an Exchange. We believe this approach leverages local expertise and experience to provide a positive experience for consumers. Since functions within an Exchange will be handled consistently, consumers comparing plans within an Exchange will benefit from standardization. In addition, based on comments received, we provide States with additional options for determining eligibility under a State-based and

Federally-facilitated Exchange in this final rule.

A. Part 155 - Exchange Establishment Standards and Other Related Standards under the Affordable Care Act

1. Subpart A - General Provisions

a. Basis and Scope (§155.10)

Proposed §155.10 of subpart A specified the general statutory authority for and scope of standards proposed in part 155, which establish minimum standards for the State option to establish an Exchange; minimum Exchange functions; eligibility and enrollment of qualified individuals, including for advance payments of the premium tax credit and cost-sharing reductions; enrollment periods; minimum SHOP functions; eligibility and enrollment of qualified employers and employees in a SHOP; and certification of QHPs. We did not receive specific comments on this section and are finalizing the provision as proposed.

b. Definitions (§155.20)

Under §155.20, we set forth definitions for terms that are used throughout part 155. For the most part, the definitions presented in §155.20 were taken directly from the Affordable Care Act or from existing regulations, though some new definitions were created when necessary.

We proposed definitions or interpretations for "Exchange," "advance payments of the premium tax credit," "annual open enrollment period," "applicant," "cost-sharing reductions," "initial enrollment period," and "special enrollment period." In addition, in the Exchange Eligibility proposed rule, we included a definition for "application filer."

Comment: A few commenters suggested that the term "applicant" only apply to individuals seeking coverage for themselves. Another commenter sought clarification as to whether the term applies only to modified adjusted gross income (MAGI)–based Medicaid

applicants or to all Medicaid applicants.

Response: We have revised the definition of the term "applicant" to apply only to individuals who are seeking eligibility for coverage for themselves or their family. The proposed definition included an individual who is seeking eligibility for advance payments of the premium tax credit and cost-sharing reductions who might not be seeking coverage for himself or herself (for example, in a situation in which a parent is seeking coverage only for his or her children); we have removed these programs from the definition of applicant as part of this clarification. Revising this definition is important to clarify that certain provisions of subpart D (for example, verification of citizenship and lawful presence) only apply to individuals who are seeking coverage.

We also note that this term applies regardless of the results of an individual's eligibility determination. Consequently, if an individual is seeking coverage and he or she is ultimately determined eligible for Medicaid in a non-MAGI category, he or she was still an "applicant." We further clarify that the term "applicant" applies regardless of whether an application was submitted directly to the Exchange, or if an application was submitted to an agency administering an insurance affordability program (for example, the State Medicaid or CHIP agency) and then transmitted to the Exchange.

Comment: We received comments suggesting that the definition of "application filer," described in §155.300(a), incorporate language included in Medicaid proposed regulations at 42 CFR 435.907, allowing that applications be completed by "the applicant, an authorized representative, or someone acting responsibly for the applicant."

Response: In the final rule, we amend the definition of "application filer" in proposed §155.300 to align with the description of individuals who may submit an application according

to §155.405(c) of this final rule as well as the Medicaid final rule, and to include: applicants; an adult who is in the applicant's household, as defined in 42 CFR 435.603(f), or family, as defined in section 36B(d)(1) of the Code; authorized representatives; or, if the applicant is a minor or incapacitated, someone acting responsibly on behalf of the applicant.

Comment: A few commenters suggested that defining "benefit year" as a calendar year may be confusing to some industries where such term is not used in the same way. Others asked how this definition impacts the calculation of deductibles and out-of-pocket limits.

Response: The term "benefit year" is defined only for the purposes of this regulation and does not change the industry's use of the term. In this final rule, as in the proposed rule, we use "benefit year" to refer to the calendar year of coverage provided through the Exchange. The calculation of deductibles and cost-sharing limits described in section 1302(c) of the Affordable Care Act will be addressed in future regulations.

Comment: One commenter recommended we should define "consumer" to include enrollees, qualified employers, qualified individuals and qualified employers. One commenter requested that "person" be more clearly defined to be limited to individuals acting as brokers or agents, because in some States the word "person" is defined to include entities such as a company, insurer, association, or an organization.

Response: In response to the comments, we have tried to limit the use of the terms "consumer" and "person" to reduce ambiguity and any confusion. When possible, we say "individual" when the terms "applicant, qualified individual, or enrollee" are not suitable. The definition of agent or broker is inclusive of individuals, companies, insurers, associations, organizations, and any other entity that holds a license as an agent, broker, or insurance producer. This final rule does not define "person."

Comment: Some commenters suggested that we codify the definition of "educated health care consumer in section 1304(e) of the Affordable Care Act.

Response: We have added this definition to §155.20.

Comment: Two commenters sought clarification on whether the term "Exchange" includes both the individual market and SHOP components of an Exchange.

Response: The definition of "Exchange" includes the phrase "makes QHPs available to qualified individuals and qualified employers" and thus incorporates the Exchange functions that serve both the individual and small group markets. Governance of an independent SHOP is addressed in §155.110(e) and unique standards for the SHOP are outlined in subpart H of this final rule.

Comment: One commenter suggested that we define what it means for an Exchange to "make available" QHPs.

Response: We believe that this regulation in its entirety defines what it means to "make available" QHPs in terms of certifying QHPs, displaying comparative QHP information, determining eligibility for enrollment, facilitating enrollment, and providing consumer assistance.

Comment: One commenter requested that we define the term "entities eligible to carry out Exchange functions."

Response: We define what entities are eligible to carry out Exchange functions in §155.110(a) of this final rule, and believe that a definition in §155.20 would be duplicative.

Comment: Several commenters recommended that the final rule include a definition of "family" and that it be based on definitions used by Office of Personnel Management or the Department of Labor, or as defined under the Family and Medical Leave Act. Commenters urged

the definition to capture the diversity and variety of family structures. Several commenters noted that a definition will promote clarity and consistency in the implementation of proposed §156.255.

Response: For purposes of the administration of advance payments of the premium tax credit and cost-sharing reductions, this final rule cross-references and incorporates from section 36B of the Code the definition of "household income." That definition relies on an identification of members of the "family" that is based on section 36B of the Code, which will be finalized as part of the Treasury rule. We intend this final rule to align with the Code as implemented by the Secretary of the Treasury's final rules. This final rule, at §155.320(c)(2)(i), provides that an application filer must provide an attestation to the Exchange regarding the individuals that comprise his or her household for purposes of Medicaid and CHIP eligibility (within the meaning of 42 CFR 435.603(f)). Please refer to part 155 subpart D for a more detailed discussion of this topic. We note that we are not finalizing the provisions of §156.255(c).

Comment: Several commenters stated that the definition of "qualified employer" should include a multi-employer plan as defined in ERISA Section 3(37), and that "qualified employee" should include individuals who are participants in a multi-employer plan, not just individuals who are employed by a qualified employer.

Response: We do not think that the law supports accepting the commenters' suggested changes in the definitions of "qualified employer" and "qualified employee." Accordingly, we have not changed the definitions in the final rule. We intend to address commenters' concerns surround multi-employer and church plans in future guidance.

Comment: We received numerous comments regarding the types of plans that should be considered health plans eligible for certification as QHPs. A few commenters suggested that

multiple employer welfare arrangements (MEWAs) be allowed to offer plans through the Exchange, be allowed to offer plans only in the SHOP and not the individual market, and be allowed to restrict enrollment to specific industry members or associations. A small number of commenters also suggested that Taft-Hartley plans and church plans be available through the Exchange. Other commenters urged HHS to ensure that all QHPs offered through the Exchange meet the same standards to ensure a level playing field and questioned the ability of self-insured employer groups to comply.

Response: We finalize the definition of a health plan as codified from section 1301(b)(1) of the Affordable Care Act, and the standards set forth for participation in an Exchange are equally applicable to any health insurance issuer seeking certification of health plans as QHPs. We intend to address issues related to multi-employer and church plans in future guidance.

Comment: Many commenters recommended HHS adopt an expansive definition of "lawfully present" that includes all prospective qualified individuals. A few commenters suggested that our definition be based on the current definition in section 214 of the Children's Health Insurance Program Reauthorization Act (CHIPRA, P.L. 111-3) or definitions proposed by the National Immigration Law Center and Asian and Pacific Islander American Health Foundation. Several commenters recommended that States have flexibility to continue using existing standards for lawfully present, as long as the rules are no more restrictive than Federal law. Many commenters recommended that we clarify that any list of "lawfully present" immigration categories is not exhaustive, as statuses and documents are constantly evolving.

Many commenters also suggested a range of additional categories to be included in the lawfully present definitions, including individuals whose immigration status makes them eligible to apply for an Employment Authorization Document regardless of whether they have secured a

work permit under 8 CFR 274a.12; certain victims of trafficking who have been granted "continued presence"; individuals granted a stay of removal/deportation by administrative or court order, statute, or regulations; individuals who are lawfully present in the Commonwealth of the Mariana Islanders and American Samoa; individuals Permanently Residing in the U.S. under Color of Law; and asylum applicants (including pending applicants for asylum under section 208(a) of the Immigration and Nationality Act (INA), or for withholding of removal under section 241(b)(3) of the INA or Convention Against Torture).

Response: We maintain the definition of "lawfully present" as used in the Pre-Existing Condition Insurance Plan, which is consistent with the definition of "lawfully present" used in section 214 of CHIPRA, and included in the proposed rule. HHS will consider commenters' recommendations in developing future rulemaking on this definition as it relates to Medicaid, CHIP, and the Exchanges.

Comment: Several commenters recommended we adopt the broad, U.S. Census data definition for "limited English proficient" which is "an individual whose primary language is not English and who speaks English less than very well."

Response: In the final rule, we do not adopt a definition for the phrase "limited English proficient." We anticipate issuing future guidance that will interpret this term and will provide best practices and advice related to meaningful access standards for limited English proficient individuals.

Comment: One commenter recommended that the definition for "minimum essential coverage" include both defined contribution and defined benefit plans, allowing individuals to use any health care funds to maximize their purchasing power. Another commenter suggested that the Federal definition of "eligible employer sponsored plan" be such that in circumstances

that an employer is not able to provide a threshold of quality coverage, a defined contribution combined with premium tax credits should be provided in the individual market Exchange.

Response: The definitions of "minimum essential coverage" and "eligible employer sponsored plan" are provided in section 5000A(f) of the Code and will be interpreted in Treasury guidance. The provisions of the Affordable Care Act that we implement through this final rule rely on those definitions from the Code.

Comment: One commenter believes that Navigators should not be an individual person, but rather a regulated entity/institution, noting that awarding Navigator grants to individuals will increase the potential for fraud and consumer protection violations.

Response: We maintain the definition for "Navigator" from the proposed rule. However, we have added Navigator standards in §155.210(b) that are intended to reduce the potential for fraud and increase consumer protection.

Comment: Regarding the definition of "plain language," one commenter recommended that all communications be provided in the individual's primary language. Several commenters recommended that we align with the National Institutes of Health's definition of "plain language," including standards that communications be written between a fourth and sixth grade reading level, include non-written visuals, and reflect the likelihood that a proportion of individuals accessing the Exchange will not be familiar with utilizing online technologies.

Response: We maintain the definition of "plain language" as codified from section 1311(e)(3)(B) of the Affordable Care Act, which directs HHS and the Department of Labor to jointly develop and issue guidance on best practices of plain language writing.

Comment: One comment voiced concern that the definition of "qualified health plan" might potentially undermine a State that wanted to implement a standard that QHP issuers offer

their QHPs outside of an Exchange.

Response: We note that, consistent with the Affordable Care Act provisions that address how issuers of QHP may offer their products, nothing in this final rule precludes a QHP issuer from offering a QHP outside of an Exchange, which we believe leaves flexibility for States to establish the offering of QHPs outside of the Exchange as a condition of certification.

Comment: We received comments throughout to add the phrase "and stand-alone dental plans providing the pediatric dental essential health benefit" when referring to QHPs. One commenter requested that we define "stand-alone dental plan."

Response: In general, with some exception as noted in new §155.1065(a)(3) of this final rule, we consider stand-alone dental plans to be a type of "qualified health plan," and therefore believe that the addition of the suggested text is unnecessary. We believe that §155.1065 sufficiently defines "stand-alone dental plan" for the purposes of participation in an Exchange, and a definition in §155.20 would be duplicative.

Comment: We received several comments about the applicability of Medicare Secondary Payer (MSP) rules regarding coverage of End Stage Renal Disease (ESRD) and their applicability to QHPs as group health plans. These comments were received within the context of several sections, including: §155.20, which defines the terms "health plan" and "qualified health plan"; §155.705 (Functions of a SHOP); §155.1000 (Certification Standards for QHPs); and §156.200 (QHP Participation Standards). Commenters recommended that MSP rules regarding coverage of ESRD apply to QHPs as group health plans.

Response: We clarify that QHPs offered in the small group market fall under the definition of a group health plan subject to MSP provisions codified in section 1862(b)(1) of the Social Security Act. This would result in parity between the SHOP and non-Exchange small

group market regarding the applicability of MSP rules that pertain to ESRD coverage.

Comment: A few commenters suggested that the definition of "State" include the Territories.

Response: The definition of State is based on section 1304 of the Affordable Care Act, which does not include Territories. Section 1323 of the Affordable Care Act addresses Territories in the context of Exchanges and is not within the scope of this regulation.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.20, with the addition of the term "educated healthcare consumer," which references the statutory definition for such term. As discussed in later sections, we also add a definition for "application filer" and "Exchange Blueprint" to provide more detail for the purposes of eligibility and enrollment and approval of State-based Exchanges. We also clarified the definition of "applicant." Finally, we have replaced the text of definitions copied from the Affordable Care Act with a direct reference instead, including: "eligible-employer sponsored plan," "grandfathered health plan," "health plan," "individual market," "plain language," and "small group market."

<HD3>2. Subpart B - General Standards Related to the Establishment of an Exchange

The Affordable Care Act sets forth general standards related to the establishment of an Exchange and identifies a number of areas where States that choose to operate an Exchange may exercise operational discretion. This subpart sets forth approval standards for State-based Exchanges, as well as the process by which HHS will determine whether a State-based Exchange meets those standards.

a. Establishment of a State Exchange (§155.100)

We proposed to codify the option for States to elect to establish an Exchange to serve

qualified individuals and qualified employers, provided that the Exchange is a governmental agency or non-profit entity established by the State and that the governance structure of the Exchange is consistent with §155.110. Furthermore, we introduced the concept of a State Partnership model that would allow States to leverage work done by other States and the Federal government.

Comment: Many commenters supported the general approach of State flexibility in the Exchange establishment proposed rule, while some urged additional flexibility and others requested more uniformity to decrease administrative complexity. Some topics where more uniformity was suggested include: minimum numbers of board meetings, conflict of interest standards, stakeholder consultation, call centers outside of normal hours, types of consumer outreach, notices, and access for limited English proficient individuals. Several commenters urged HHS to establish a menu of systems, functions, standard operating procedures, educational materials, reporting formats, and other tools that States could adopt for their Exchanges. One commenter suggested that States that use the HHS templates should receive an accelerated review process.

Response: Decreasing administrative complexity will assist States in Exchange establishment. States are encouraged to make use of materials available to them from other States and on HHS's Collaborative Application Lifecycle Tool (CALT). HHS is also developing a web portal that will allow continued sharing of information, business process flows, and templates to aid States in the establishment of their Exchange.

Comment: One commenter requested clarification on proposed §155.100(a) regarding whether a State could only establish a SHOP, and not an Exchange to serve the individual market. Other commenters urged HHS not to allow administrative separation of the small group

and individual markets between a State-based and Federally-facilitated Exchange.

Response: HHS will approve a State-based Exchange upon determining that all minimum functions of an Exchange are met, which includes providing access to QHPs to qualified individuals and to qualified employers through a SHOP.

Comment: In relation to proposed §155.100(b), several commenters voiced support of the option for Exchanges to be operated through a non-profit or governmental entity. One commenter requested clarification on what is encompassed in "governmental." Some commenters were concerned about accountability of non-profit entities and encouraged States to establish governmental or quasi-governmental entities. Several commenters requested clarification that stakeholders would still need to be consulted regardless of the governance entity.

Response: The discretion afforded States outlined in section 1311(d)(1) of the Affordable Care Act is critical. We do not provide additional clarification regarding what would be considered "governmental" in deference to existing State classifications. We note that §155.130 of this final rule applies to all Exchanges.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.100 of the proposed rule without modification.

b. Approval of a State Exchange (§155.105)

In §155.105, we proposed that the Secretary must determine by January 1, 2013 whether a State's Exchange will be fully operational by January 1, 2014 and outlined the proposed standards based upon which HHS will approve a State Exchange. Please refer to the preamble of the Exchange establishment proposed rule, at 76 FR 41870-41871, for a detailed discussion of

these standards.

Specifically, we outlined the process through which HHS will approve a State-based Exchange. We proposed that to initiate the State Exchange approval process, a State must submit an Exchange Plan to HHS. We noted that we planned to issue a template outlining the components of the Exchange Plan, subject to the notice and comment process under the Paperwork Reduction Act. We proposed that each State receive written approval or conditional approval of its Exchange Plan in order to operate and to constitute an agreement between HHS and the Exchange to adhere to the contents of the Exchange Plan. We also proposed that a State must notify HHS and receive written approval from HHS before significant changes are made to the Exchange Plan. We sought comment on whether the State Plan Amendment process offered an appropriate model for change submission and approval.

Finally, we proposed to codify the provision in the Affordable Care Act that if a State elects not to establish an Exchange - or if the State's Exchange is not approved - HHS must establish an Exchange in that State, and we proposed standards of the proposed rule that would apply to a Federally-facilitated Exchange.

Comment: Many commenters were concerned that the approval date of January 1, 2013 for State-based Exchanges, as described in proposed §155.100(a), will be difficult for many States to meet and suggested that HHS allow more flexibility or issue waivers for States that cannot meet the timeframes. One commenter suggested that HHS approve an Exchange if a State has passed enabling legislation, or has the necessary regulatory process for Exchange creation underway by January 1, 2013, and can provide HHS with a detailed plan and timeline for Exchange development. In contrast, several commenters supported the January 1, 2013 approval deadline and requested that HHS closely monitor and enforce the implementation timeline.

Several commenters also supported conditional approval and noted that it could help States meet the timelines for Exchange development. One commenter requested additional information on conditional approval, including the latest date when HHS could revoke conditional approval and interim deadlines and benchmarks. Another commenter did not support conditional approval and felt it diluted Federal scrutiny, while others expressed concern that conditional approval would result in States beginning open enrollment late, in a diminished capacity, or in a way that impairs HHS's ability to implement a Federally-facilitated Exchange.

Response: We believe that in order to meet the October 1, 2013 open enrollment date, a State-based Exchange must be approved or conditionally approved by January 1, 2013, as called for in section 1321(c)(1)(B) of the Affordable Care Act. HHS may conditionally approve a State-based Exchange upon demonstration that it is likely to be fully operationally ready by October 1, 2013, which provides States with flexibility in meeting Exchange development timelines. HHS will provide additional details in future guidance.

Comment: One commenter suggested that proposed §155.105(b) include additional confidentiality standards, including that an Exchange comply with section 1411(g) of the Affordable Care Act and the Privacy Act (5 U.S.C. 552a).

Response: HHS is committed to ensuring that security and privacy standards are in place in an Exchange. Security and privacy standards are addressed in §155.260 and §155.270 of this final rule. We believe it is duplicative to include these standards in §155.105(b).

Comment: Several commenters requested that the rule regarding the geographic area described in proposed §155.105(b)(4) be modified to clearly indicate that where there are multiple Exchanges, with each Exchange serving a distinct geographic area, that consumers could only use one Exchange. Several commenters suggested that HHS establish that the distinct

geographic areas be consistent with premium rating areas in the State as determined under section 2701(a)(2) of the PHS Act.

Response: In the preamble to the Exchange establishment proposed rule for §155.105, we clarified that only one Exchange may operate in each geographically distinct area and that a subsidiary Exchange must be at least as large as a rating area. We maintain this position in the final rule, which we believe provides States with discretion to ensure that subsidiary Exchange service areas are consistent with rating areas.

Comment: Several commenters requested that the proposed Exchange Plan described in proposed §155.105(c)(1) be subject to a public comment period before HHS approval. One commenter asked that HHS post documents related to the proposed Exchange Plan and operational readiness on the HHS website.

Response: We believe that accelerating timeframes to accommodate a period for public comment on what we now refer to as "Exchange Blueprints" would put unreasonable pressure on what is already perceived as a tight timeline. Therefore, in order to maintain flexibility and because of timeframe concerns, the final rule does not call for a State's Exchange Blueprint to be made public and open to comment prior to approval by HHS.

Comment: One commenter supported the proposal that the operational readiness assessment conducted by HHS, as described in proposed §155.105(c)(2), be coordinated with the monitoring process of the State Establishment Grants provided under section 1311 of the Affordable Care Act.

Response: We believe that the operational readiness assessment should be coordinated with the grants monitoring process and are currently developing guidance for the evaluation process.

Comment: In relation to proposed §155.105(d) and (e), several commenters supported using a process modeled from the Medicaid and CHIP State Plan review process for the approval of the initial Exchange and subsequent changes, including the 90-day review timeframe and posting of changes on the Internet, and because they believe that the process ensures sufficient Federal oversight and transparency. In contrast, many other commenters urged HHS to use a review plan other than the Medicaid and CHIP model, contending that the State Plan review process would delay State implementation while waiting for an HHS review that could potentially take up to 180 days. The commenters suggested that the proposed approach would be unwieldy, especially where HHS requests for additional information from States would restart the 90-day period, and would inhibit States from being able to effectively establish an Exchange and respond to changing circumstances over time.

Response: We believe that initial approval of an Exchange and approval of subsequent changes should not cause unnecessary delay in Exchange implementation or future operations. Therefore, HHS will not model the review of the initial proposed Exchange Plan or future changes after the Medicaid and CHIP State Plan process. Additionally, we have changed reference of the "Exchange Plan" to "Exchange Blueprint" to avoid confusion with the Medicaid and CHIP review process. Finally, we amended §155.105(e) to provide that when a State makes a written request for approval of a significant change to Exchange Blueprint, the change may be effective on the earlier of 60 days after HHS receipt of a completed request, or upon approval by HHS. For good cause, HHS may extend the review period an additional 30 days to a total of 90 days. We note that during the review period, HHS may deny the significant change to the Exchange Blueprint.

Comment: Several commenters sought more information and provided suggestions on the establishment and operation of the Federally-facilitated Exchange described in proposed §155.100(f), including: the overall structure, governance, oversight, and standards; how it would differ from State to State; the approach to certification of QHPs ("active purchaser" versus "any willing plan"); and, what the relationship would be between a Federally-facilitated Exchange and Partnership model. One commenter expressed concern about consumer advocates' ability to engage in the governance and oversight of a Federally-facilitated Exchange, while other commenters requested that the Federally-facilitated Exchange's planning documents and updates should be subject to public notice and comment.

Response: Information regarding the Federally-facilitated Exchange will be provided in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.105 of the proposed rule, with the following modifications: in paragraph (a), we added clarifying language regarding the timeframe for Exchange approval, and clarified that HHS may consult with other relevant Federal agencies to approve a State-based Exchange. Throughout §155.105, we changed "Exchange Plan" to "Exchange Blueprint." We included subpart D in the list of Exchange functions in paragraph (b)(2) because we are finalizing the Exchange establishment and eligibility rules together, and removed the policy that States agree to perform responsibilities related to the reinsurance program because we are not finalizing the operation of the reinsurance program in connection with Exchange establishment. We amended paragraph (e) to provide timeframes for the approval of significant changes to the Exchange Blueprint.

c. Election to operate an Exchange after 2014 (§155.106)

We proposed to give States the opportunity to seek approval to operate an Exchange after the statutory date of January 1, 2013. Specifically, we proposed that a State electing to operate an Exchange after 2014 must have in effect an approved or conditionally approved Exchange Plan at least 12 months prior to the first effective date of coverage, or January 1 of the prior year. Further, a State must work with HHS to develop a plan to transition from a Federally-facilitated Exchange (including a Partnership) to a State-based Exchange.

We also proposed a process to allow a State-based Exchange to cease its operations after January 1, 2014 and to elect to have the Federal government establish and operate an Exchange within the State, provided that the State notifies HHS of this determination 12 months prior to ceasing its operations and collaborates with HHS on the development and execution of a transition plan.

Comment: One commenter stated that the deadlines set by the Affordable Care Act for setting up a State-based Exchange are not realistic and that HHS should extend them.

Response: We understand the concerns regarding the deadlines for setting up a State-based Exchange. While we do not believe authority exists in section 1321(c) of the Affordable Care Act to alter the January 1, 2014 Exchange implementation date, we proposed §155.106 to alleviate some of the timing pressure. We maintain that approach in this final rule.

Comment: Numerous commenters supported the flexibility for a State to elect to operate an Exchange after 2014, and several requested more detail on the transition plans in proposed §155.106(a)(3). Suggestions for the transition plan included: demonstration of consumer input and tribal consultation; process for educating consumers about potential changes; process for ensuring QHP issuers have sufficient time to comply with new standards (such as a one-year grace period); and, a plan to protect enrollees from lapses of coverage. A number of commenters

recommended a State-based Exchange starting after 2014 must have similar or better levels of insured rates, affordability, covered benefits, and administrative simplicity or quality of services.

Response: We believe that it is important to develop a seamless transition plan for consumers and issuers alike, and will provide future guidance on transition plans.

Comment: Several commenters requested clarification on the process for transitioning to a Federally-facilitated Exchange in proposed §155.106(b) when a State terminates Exchange operations with less than twelve months notice to HHS. One commenter urged HHS to establish an alternative process for providing interim coverage to consumers if a State does not provide sufficient notice.

Response: We understand concerns regarding the transition timeframes. HHS will develop an approach to transitioning Exchanges in various circumstances when it becomes clearer what such circumstances would entail.

Comment: One commenter requested information as to the availability of funding options for States electing to operate an Exchange after 2014.

Response: As described in the State Exchange Implementation Questions and Answers released by HHS on November 29, 2011, establishment grants may be awarded through the end of 2014 for approved and permissible establishment activities. The process of "establishing" an Exchange may extend beyond the first date of operation and may include improvements and enhancements to key functions over a limited period of time. Generally, grants can be used to establish Exchange functions and operating systems and to test and improve systems and processes. We have determined that a State that does not have a fully approved State Exchange on January 1, 2013 may continue to qualify for and receive a grant award, subject to the Funding Opportunity Announcement (FOA) eligibility criteria.

Summary of Regulatory Changes

We are finalizing the provisions in §155.106 of the proposed rule, with a conforming, technical change that replaced "Exchange Plan" with "Exchange Blueprint" in paragraph (a)(2) and removed the word initial from paragraph (a) to make the provision more broad.

d. Entities eligible to carry out Exchange functions (§155.110)

In §155.110, we proposed to codify an Exchange's authority to contract with eligible entities, and requested comment on conflict of interest standards. We noted that the Exchange remains responsible for meeting all Federal rules related to contracted functions.

If the Exchange is an independent State agency or not-for-profit entity established by the State, we proposed that its governing board meet the standards outlined in §155.110(c)(1) through §155.110(c)(4) of the proposed rule, which included: the Exchange accountability structure must be administered under a formal, publicly-adopted operating charter or by-laws; the Exchange board must hold regular public meetings; representatives of health insurance issuers, agents, brokers, or other individuals licensed to sell health insurance may not constitute a majority of the governing board; and, all members of the governing board must meet conflict of interest and qualifications standards. We invited comment on several topics related to conflict of interest and Exchange governance.

We also proposed that the Exchange governing body ensure that a majority of members have relevant experience in a number of areas and invited comment on the types of representatives that could best ensure successful Exchange operations. We solicited comment on ethics and disclosure standards.

Additionally, we proposed to allow a State to operate its individual market Exchange and SHOP under separate governance or administrative structures, provided that the State

coordinates and shares relevant information between the two Exchange bodies and that it ensures adequate resources to assist both individuals and small employers.

Finally, we proposed that HHS retain the option to review the accountability structure and governance principles of an Exchange and requested comment on the appropriate frequency for these reviews.

Comment: A number of commenters requested clarification on whether State departments of insurance would be considered eligible contracting entities under proposed §155.110(a), citing the importance of such expertise in the operation of an Exchange.

Response: We clarify in §155.110(a)(2) of this final rule that, in addition to State Medicaid agencies, other State agencies that meet the qualifications in (a)(1) would be considered eligible contracting entities. For purposes of this final rule and Exchange operations, we interpret the term "incorporated" in (a)(1)(i) to include State agencies, such as departments of insurance, that have been established under and are subject to State law.

Comment: Several commenters urged HHS to apply conflict of interest standards to eligible contracting entities.

Response: We generally defer to States to establish conflict of interest standards for eligible contracting entities beyond the prohibition of health insurance issuers being eligible contracting entities, as established in section 1311(f)(3) of the Affordable Care Act and codified in §155.110(a)(1)(iii). We believe that many States have existing conflict of interest laws, have appropriate expertise in this area, and can support Exchanges in the development of conflict of interest standards for such entities.

Comment: Several commenters agreed with the governance provisions in proposed §155.110(c) and requested further guidance on governance, while others recommended that HHS

defer to States on governance citing concerns of burden. Another commenter suggested that all Exchanges, including an Exchange that is a State agency, needed a governing board. One commenter requested that all Exchanges post their policies and procedures on the Internet.

Response: We have afforded States substantial discretion regarding governance and do not believe that the governance standards are burdensome from an operational or systems standpoint. Additionally, to lessen the burden on States, an Exchange may use the State's conflict of interest standards, regulations, or laws for governance of the Exchange. An existing State agency would already have an accountability structure, unlike an independent agency or nonprofit entity. Therefore, we believe that a governing board is not necessary for an existing State agency, although we note that a State may choose to establish one anyway. Section 155.110(d) of this final rule directs Exchanges to make publicly available a set of guiding governance principles, which it may do through the Internet. We also create minimum standards for consumer representation on Exchange Boards to protect consumers and the interests of the Exchange without adding burden on States or Exchanges.

Comment: With respect to proposed §155.110(c)(3), a few commenters requested HHS define "represents consumer interests" and "conflict of interest." Many commenters recommended that all Exchange boards must have at least one consumer representative or advocate and a formal consumer advisory committee. A few commenters recommended increasing the threshold for voting members that do not have a conflict of interest to something higher than a simple majority.

Response: We accept the suggestion that at least one voting member be a consumer advocate, and have amended in §155.110(c)(3)(i) of this final rule accordingly. We do not believe this change will conflict with any current Exchange boards. We have also maintained the

minimum standard that a simple majority of board members not have a conflict of interest, but a State can choose to establish an Exchange with a higher threshold of non-conflicted board members.

Comment: Commenters suggested broadening the list of groups identified as having a conflict of interest in proposed §155.110(c)(3)(ii) to include: health care providers; anyone with a financial interest; anyone with a spouse or immediate family with a conflict of interest; major vendors, subcontractors, or other financial partners of conflicted parties; members of health trade associations and providers; and, health information technology companies. Commenters recommended that such groups be limited or prohibited from participation in an Exchange. Other commenters recommended that individuals with ties to the insurance industry participate through technical panel or advisory group instead of through board membership.

Response: As proposed, §155.110(c)(3)(ii) ensures as a minimum standard that the groups with the most direct conflict of interest cannot form a majority of voting members on a governing board. We believe that further definition of conflict of interest may create inconsistencies with State law and other existing State standards, but note that Exchanges may expand the list or further define conflict of interest. For example, a State may elect to prohibit any conflicted members from serving on the board.

Comment: Several commenters suggested areas in addition to those listed in proposed §155.110(c)(4) in which governing board members should have experience, including: minority health; mental health; pediatric health; consumer education or outreach; public coverage programs; health disparities; or represent or be American Indian and Alaska Natives. A few commenters suggested that the Exchange board include members that reflected the cultural, ethnic and geographical diversity of the State.

Response: Each of the suggested groups could add value to an Exchange governance board. However, we believe that a State can determine the expertise it believes would be most beneficial for the needs of its community. We note that the list in §155.110(c)(4) is a minimum; thus, States may establish governing boards standards that include expertise in other areas, or may set up advisory committees to achieve another mechanism for specialized input.

Comment: Regarding proposed §155.110(f), some commenters suggested that HHS limit review of an Exchange's governance to every three or four years, while several commenters voiced concerns about the administrative burden of an annual review. One commenter recommended an annual review but only for the first few years of Exchange operation.

Response: We have maintained language in the final rule but clarify that any changes to the accountability structure and governing principles of the Exchange will likely be reviewed under §155.105(e) of this final rule or at the discretion of HHS through a process that may not occur annually under §155.110(f).

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.110, with the following modifications: in paragraph (a)(1)(iii)(2), we clarified that any State entity that meets the qualifications of paragraph (a)(1) is an eligible contracting entity to include State departments of insurance. We established in new paragraph (c)(3)(i) that at least one member of the Exchange's board must include one voting member who is a consumer representative, and renumbered proposed paragraph (c)(3)(i) as (c)(3)(ii).

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

In §155.120, we proposed that an Exchange may not establish rules that conflict with or prevent the application of Exchange regulations promulgated by HHS. We also proposed to

codify that nothing in title I may be construed to preempt any State law that does not prevent the application of the provisions set forth under title I of the Affordable Care Act. In addition, we proposed that a State must comply with any applicable non-discrimination statutes, specifically that a State must not operate an Exchange in such a way as to discriminate on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.

Comment: One commenter suggested that HHS ensure that contractors comply with the non-discrimination provisions of proposed §155.120. One commenter recommended HHS amend §155.120(c) to explicitly name specific activities of the Exchange, including marketing, outreach, and enrollment in the Exchange.

Response: We clarify that §155.120 applies to Exchange contractors and believe this notion is conveyed in §155.110(b) for contractors. We believe that §155.120 already applies to all activities of the Exchange, and thus do not explicitly list marketing, outreach, and enrollment.

Comment: Several commenters recommended that HHS specify that proposed §155.120(b) functions as a floor for protection against discrimination. The commenters stated that in the event a State law provides additional consumer protections in an Exchange, the final rule should make clear that such a State law will prevail over the minimum protections codified in Federal law.

Response: We believe the proposed approach of codifying section 1321(d) of the Affordable Care Act does not preclude the application of stronger protections in the Exchange provided by State law. Therefore, we do not make any further changes in the regulations to make this clarification.

Comment: A number of commenters requested that HHS provide clarification on proposed §155.120(c)(1) and specify which statutes would be considered "applicable non-

discrimination statutes," with suggestions including the Americans with Disabilities Act, section 504 of the Rehabilitation Act, section 1557 of the Affordable Care Act, provider non-discrimination in accordance with section 2706 of the PHS Act. One commenter recommended that HHS ensure that States and Exchanges comply with existing State provider non-discrimination laws and another recommended that we amend the §155.120(c)(1) to include consumer protection laws.

Response: We clarify that by "applicable non-discrimination statutes," we mean any statute that would apply to Exchange activities by its clear language or as consistent with any rulemaking that has been established in accordance with such statutes. We acknowledge that the some non-discrimination statutes apply to specific activities and situations, and an Exchange must comply with such statutes to the extent its activities or circumstances would be subject to these standards.

Comment: We received a comment on the preamble to the proposed §155.120(c)(2). The commenter recommended that HHS delete the phrase "operating in such a way as to discriminate" or revise the nondiscrimination standard to prohibit discrimination based "solely" on the listed grounds.

Response: To clarify, we believe that Exchanges should not discriminate in any way on the basis of groups listed in §155.120(c)(2). We believe that the regulatory text conveys that intent.

Comment: A number of commenters recommended HHS amend proposed §155.120(c)(2) to add categories to the proposed list, including Indians or individuals in the Lesbian, Gay, Bisexual, and Transgender (LGBT) community, individuals with limited English proficiency, and people with disabilities.

Response: We recognize the commenters' concerns but we are maintaining the categories specified in §155.120(c) because we believe that categories not listed in §155.120(c)(2) are already protected by existing laws that apply to Exchanges.

Comment: A number of commenters requested that HHS provide clarification on the oversight and enforcement of the non-discrimination standards, including recommendations for strong oversight, the establishment of a clear complaints process, and mandatory public dissemination of an acknowledgement by QHP issuers that they comply with the non-discrimination standards in section 1557 of the Affordable Care Act.

Response: We acknowledge the commenters' concerns regarding the monitoring and enforcement of the non-discrimination policies. We plan to issue future guidance on the oversight and enforcement of the non-discrimination standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.120 of the proposed rule, with a technical change to include part 157 in paragraph (b).

f. Stakeholder consultation (§155.130)

Consistent with the Affordable Care Act, we proposed that Exchanges consult with certain groups of stakeholders on an ongoing basis. The list of stakeholders identified were the following: educated health care consumers who are enrollees in QHP; individuals and entities with experience in facilitating enrollment in health care coverage; advocates for enrolling hard to reach populations; small businesses and self employed individuals; State Medicaid and CHIP agencies; Federally-recognized Tribes; public health experts; health care providers, large employers; health insurance issuers; and agents and brokers. For a more complete list of stakeholders and for a discussion of how Exchanges may interact with tribes, please refer to page

41873 of the Exchange establishment proposed rule.

Comment: Some commenters requested clarification on what it means to "regularly consult on an ongoing basis," as described in proposed §155.130, and suggested that we clarify that an Exchange must consult with stakeholders beyond establishment of the Exchange, outlining specific processes for consultation (including public meetings and input sessions), and specifying that Exchange activities must be topics of consultation (including the call center, website, consumer assistance functions and Navigators).

Response: We recognize that it is important to utilize various methods of consultation to ensure the Exchange meets the diverse needs of the State's population and seeks input on a broad set of issues. However, we believe that States are in the best position to determine what will be the most efficient and effective methods of stakeholder consultation for meeting the State's unique needs and, therefore, we do not establish additional standards in the final rule.

Comment: Many commenters recommended that HHS add additional categories of stakeholder groups to proposed §155.130, including: a nonprofit community organization; unions; representatives of individuals with disabilities; minorities; advocates for individuals with limited English proficiency; essential community providers; employees of small businesses; stand-alone dental plans; health care consumer advocates; experts in low income tax policy; experts in privacy policy; and professional organizations representing specific health care providers. Several commenters requested clarification on what types of health insurance issuers and providers fall under the categories for consultation. A few commenters suggested that we narrow the list of stakeholders.

Response: We recognize that Exchange consultation with the above groups would help the Exchange ensure it can meet the needs of the population it serves. However, we believe that

the categories proposed in §155.130 are broad enough to encapsulate a wide variety of stakeholders, and encourage Exchanges to consult with any other stakeholders that will add perspective to the development of an Exchange. Similarly, we did not accept suggestions to make the stakeholder categories narrower and believe the minimum list proposed will stimulate stakeholder participation. Exchanges have the flexibility to determine what types of stakeholders would fall under each of the categories.

Comment: Regarding proposed §155.130(a), one commenter was concerned that including "educated health care consumer" as a stakeholder unfairly excludes people of a certain education level. Another commenter recommended that HHS delete the word "educated" from "educated health care consumer" to avoid multiple interpretations. Numerous commenters recommended that HHS replace "educated health care consumer" with "health care consumer experienced with the system." One commenter suggested that the definition of "educated health care consumers" take into account the diversity in the age, background, and health status of consumer stakeholders. A few commenters suggested that HHS expand the stakeholder group to include consumers who are eligible or likely to enroll in a QHP in addition to those consumers enrolled in QHPs.

Response: We note that the term "educated health care consumer" is defined in section 1304(e) of the Affordable Care Act to mean an individual who is knowledgeable about the health care system, and has background or experience in making informed decisions regarding health, medical, and scientific matters; we have codified this definition in §155.20 of this final rule. An Exchange can interpret and apply the term in the way that is most appropriate for its environment consistent with this definition.

Comment: Regarding proposed §155.130(f), commenters recommended that the final rule

prohibit States from delegating consultation with Federally-Recognized Tribes to the governing bodies operating the Exchange. Commenters noted that establishing Exchanges as independent public entities would make stakeholder consultation difficult to monitor consultation with Tribes. Several commenters suggested that a tribal consultation policy be developed and approved by the State, the Exchange, and tribal governments prior to the submission of approval of an Exchange Blueprint. Some commenters also recommended that States must utilize a process for seeking advice from the Indian Health Service, tribal organizations, and urban Indian organizations as outlined in section 5006(e) of the American Recovery and Reinvestment Act. Also, one commenter requested HHS to expand the tribal consultation standard to include any tribal organization or inter-tribal consortium as defined in the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act.

Response: Section 1311(d)(6) of the Affordable Care Act directs the Exchange to carry out consultation with stakeholders, and §155.130(f) codifies this provision with respect to Federally-recognized Tribes. We note that Exchange tribal consultation reflects a government-to-government relationship, as Exchanges would conduct consultation on behalf of States. Future guidance will be provided to States regarding key milestones, including tribal consultation, for approval of a State-based Exchange. Because of the government-to-government nature of tribal consultation, we did not include a provision similar to section 5006(e) of the American Recovery and Reinvestment Act in the proposed rule or in this final rule, and did not expand the tribal consultation standard to include tribal organizations, programs, or commissions. In the final rule, Exchanges must consult with Federally-recognized Tribes; however, this does not preclude Exchanges from engaging in discussions or consulting with tribal and Urban Indian organizations. It should be noted that when a tribal or Urban Indian organization is a stakeholder

as defined in §155.130 - for example, the tribal or Urban Indian organization is a health care provider - then consultation may be necessary. We therefore encourage States to consult with tribal and Urban Indian organizations.

Comment: Some commenters recommend that as a component to the ongoing tribal consultation standard in proposed §155.130(f), the Exchange should establish an "Indian desk" with the lead person identified and contact information provided, and extend the authority of CMS Native American Contacts to include facilitating and interacting with the State Exchange governing bodies.

Response: We did not accept the suggestion that all Exchanges must establish an "Indian Desk." States have discretion to determine appropriate approaches and mechanisms for interacting with the Tribes, providing information to Indian Country and for meeting the needs of American Indians/Alaska Natives, which can be determined during the tribal consultation process. We also did not accept the suggestion related to the CMS Native American Contacts. While we recognize that the Native American Contacts have a critical role in working with States and Tribes, structuring the responsibilities of CMS staff positions is not within the scope of this final rule.

Comment: A few commenters suggested that the final rule enforce tribal consultation by Exchanges in the planning, implementation and operation of State-based Exchanges, and ensure adequate funding for the technical assistance provided by tribal entities to States and Exchanges. One commenter expressed a concern that Exchanges may not be able to process eligibility and enrollment information regarding American Indians/Alaska Natives unless they are included in policy and regulation development. Some commenters strongly urge CMS to work with Tribes to undertake a thorough education of State insurance commissioners on issues related to Indian law,

the structure of the Indian health care delivery system, and protocols for consulting with Tribes, since many Tribes do not have experience working with insurance commissioners.

Response: We did not accept the suggestion for Exchanges to obligate State grant funding for technical assistance provided by tribal entities to States and Exchanges. We believe that the concern regarding Exchange inclusion of American Indians and Alaska Natives in policy development is addressed in the final rule and the Exchange Establishment Grant, which directs Exchanges to consult with Federally-recognized Tribes. We note that education of State health insurance commissioners on Indian law will be addressed at the operational level of CMS.

Comment: We received a number of comments stating that HHS should limit the number of consultations with health insurance issuers, agents, and brokers described in proposed §155.130(j) and (k) to minimize any potential conflicts of interest. One commenter recommended that consultation with a health insurance issuer be made fully transparent, while several other commenters recommended that the consultation only include agents and brokers that enroll qualified individuals, employers, or employees.

Response: We understand the concerns of commenters, but also acknowledge that health insurance issuers and agents and brokers are likely to play a significant role in the Exchange. We encourage Exchanges to be transparent in the consultation process. Furthermore, in States where the Exchange is not housed in the department of insurance, we expect there to be regular consultation between the Exchange and the department of insurance, given the need for coordination between the two entities.

Comment: One commenter recommended that stakeholder input should contribute to both State-based Exchanges and Federally-facilitated Exchanges.

Response: As indicated in §155.105(f), the stakeholder standards of §155.130 apply to

both Federally-facilitated Exchanges and State-based Exchanges.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.130 of the proposed rule without modification.

g. Establishment of a regional Exchange or subsidiary Exchange (§155.140)

In §155.140, we outlined several proposed features of regional Exchanges, including that a regional Exchange would encompass two or more States and could submit a single Exchange Blueprint, and the criteria that the Secretary will use to approve such an Exchange.

Specifically, we proposed that a State may establish one or more subsidiary Exchanges if each such Exchange serves a geographically distinct area that is at least as large as a rating area described in section 2701(a) of the PHS Act. We invited comment on operational or policy concerns related to subsidiary Exchanges that cross State lines. We also requested comment on the extent to which we should allow more flexibility in the structure of a subsidiary Exchange.

Finally, we proposed basic standards for a regional or subsidiary Exchange. For a complete discussion of the proposed standards, please see pages 41873-41874 and 41914 of the Exchange establishment proposed rule.

Comment: Regarding proposed §155.140(a), several commenters supported the flexibility to establish regional Exchanges so that States could share Exchange infrastructure and systems. However, other commenters had concerns regarding the applicability of State standards across a regional Exchange. Some were concerned about coordinating the regulation of QHP issuers in a regional Exchange to ensure each State's insurance standards were met, especially regarding licensure and solvency, and others raised concerns about coordination between the Medicaid agencies of multiple States regarding consistency of eligibility determinations and provider

payments. Other commenters were concerned that consumer protections, including State non-discrimination laws, minimum benefit standards, network adequacy, complaints processes, and tribal consultation, would be potentially undermined by a regional Exchange (particularly one that crosses non-contiguous States). Some commenters suggested that States must provide a compelling reason to establish a regional Exchange to help preserve consumer protections.

Response: We acknowledge the commenters' concerns regarding coordination across States. We note that in §155.140(c)(1), we establish that a regional or subsidiary Exchange must meet all Exchange standards, which would include, for example, the standard in §156.200(b)(4) that a QHP issuer be licensed and in good standing in each State in which it offers coverage. We believe that this and other provisions in the final rule provide some clarity on coordination. We recognize the concerns regarding consumer protection, and HHS will take those into account on a case-by-case basis during review of a regional Exchange Blueprint.

Comment: With regard to proposed §155.140(a), one commenter requested clarification on whether a regional Exchange would need to cover the entirety of each State, and another requested clarification on whether two States could share administrative resources without sharing governance.

Response: We note that in §155.140(c)(1), a regional Exchange would have to comply with all Exchange standards, including §155.105(b)(3), which directs a State to ensure that the entire geographic area of a State is covered by an Exchange. A State has flexibility in the way it meets this standard. We believe that States are able to share administrative and operational resources to the extent practicable, and would not be considered a regional Exchange unless they also shared governance, consumer assistance, enrollment and eligibility processes, QHP certification authority, and the SHOP.

Comment: Regarding proposed §155.140(b), a number of commenters did not support the proposed rules regarding subsidiary Exchanges out of concern for consumer protections, consumer confusion, administrative complexity, the effect of smaller risk pools, and the ability for subsidiary Exchanges to exacerbate adverse selection. Commenters suggested that a State must demonstrate a compelling justification as to how a subsidiary Exchange would be in the best interest of consumers. Some commenters suggested that subsidiary Exchanges should remain under centralized State governance and policy decisions to provide some consistency across the State. A number of commenters supported the provision in proposed §155.140(b)(2) that ensures a subsidiary Exchange is as large as a rating area because they believe it would prevent risk selection. Several commenters urged HHS not to allow subsidiary Exchanges to cross State lines while others supported the concept.

Response: We recognize the concerns of commenters related to the consumer experience under subsidiary Exchanges, but we believe that such Exchanges may be valuable and appropriate in some marketplaces. In reviewing a State's Exchange Blueprint, HHS will consider how best to protect the consumer experience.

Comment: A few commenters requested clarification on whether an Exchange can be statewide for the individual market with several SHOPs operated through subsidiary Exchanges. Several commenters supported the alignment of SHOP and individual market Exchange service areas to ensure consistency for consumers and insurers, and for a more robust insurance market.

Response: In this final rule, we maintain the standard in §155.140(c)(2)(ii) that the service areas of a SHOP and individual market Exchange must match.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.140 of the proposed rule without

modification.

h. Transition process for existing State health insurance exchanges (§155.150)

In §155.150, we proposed that, unless determined to be non-compliant, a State operating a pre-Affordable Care Act exchange is presumed to be in compliance with the standards set forth in this part if: (1) The exchange was operating before 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. We invited comment on which proposed threshold should be used and on alternative data sources. We also proposed that any State that is currently operating a health insurance exchange that meets these criteria must work with HHS to identify areas of non-compliance with the standards of this part.

Comment: A small number of commenters had suggestions for proposed §155.150(a). A few commenters suggested that we use the Congressional Budget Office estimates for projected coverage in 2016 and others recommended the Census Bureau's American Community Survey or the Current Population Survey estimates of State coverage on January 1, 2010. A number of commenters suggested using a source that included Urban Indian-specific data, while another commenter suggested the coverage numbers be based on non-elderly State residents only. One commenter raised concerns that coverage numbers are calculated inaccurately at the State level.

Response: We have amended proposed §155.150(a)(2) to reference the Congressional Budget Office projected coverage numbers published on March 30, 2011. HHS will work with any State that believes it would fall into this category to determine if its State coverage numbers were equal to or above that threshold in January of 2010.

Comment: Several commenters suggested that proposed §155.150(b) should provide additional information, provide for an expedited review process, make corrective action plans

publicly available, establish that determining compliance will occur by fall 2012, and otherwise remain consistent with the January 1, 2013 timeframe for Exchange approval.

Response: We believe that any State that qualifies under §155.150(a) would continue to generally meet all standards for Exchange approval as established elsewhere in the final rule, including the process for review and timeframes, so we do not believe it necessary to outline standards in this section.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.150 of the proposed rule, with the exception of specifying the database for the projected coverage numbers upon implementation.

i. Financial support for continued operations (§155.160)

In §155.160, we proposed to codify the statutory provision that a State ensure its Exchange has sufficient funding to support ongoing operations beginning January 1, 2015 and develop a plan for ensuring funds will be available. Specifically, we proposed to allow a State Exchange to fund its ongoing operations by charging user fees or assessments on participating issuers or by generating other forms of funding, provided that any such assessments are announced in advance of the plan year. We invited comment on whether the final regulation should otherwise limit how and when user fees may be charged, and whether such fees should be assessed on an annual basis.

Comment: In response to proposed §155.160, several commenters stated that an Exchange must not be approved by HHS unless a clear plan to achieve financial sustainability has been articulated. Further, commenters recommended that an Exchange also address the implications of its selected fee structure with respect to adverse selection and identify strategies to mitigate this risk.

Response: A clearly defined plan for financial sustainability is essential to Exchange success and in §155.160(b), we codify section 1311(d)(5)(A) of the Affordable Care Act, which establishes that a State ensure that its Exchange has sufficient funding to support its operations beginning January 1, 2015. As noted in the preamble to the proposed rule, a funding plan is necessary for Exchange approval. States should conduct an analysis of various user fee structures as well as other financial support options before making a decision. This analysis could include, among other factors, the potential impact on risk selection, issuer participation, consumer experience, and provider contracting. We maintain the codification in this final rule.

Comment: With respect to proposed §155.160(b), many commenters offered specific recommendations on how Exchanges should generate revenue, including methods for calculating assessments, such as percent of premium with or without a cap; per-policy fees; or establishing fees at a specified amount. Commenters also recommended uniform notice standards, such as 10 or 12 months in advance of the relevant plan or benefit year, or in March of each year. A few commenters recommended specific frequencies of collection, such as monthly.

Response: The Affordable Care Act directs Exchanges to be self-sustaining and provides flexibility for Exchanges to generate support for continued operation in a variety of ways, such as through user fees. Accordingly, we do not limit Exchanges' options in the final rule by prescribing or prohibiting certain approaches. We believe that user fees parameters, as well as the need for other revenue-generating strategies, may vary by State depending upon several factors such as the number of potential enrollees and the Exchange's operational costs. Consistent with this flexibility, we have not finalized the proposal that the Exchange announce user fees in advance of the applicable plan year, and instead look to Exchanges that opt to charge user fees to establish a deadline and vehicle for such announcement, as well as the frequency

with which the Exchange will collect such fees.

Comment: Some commenters expressed support for the flexibility provided with respect to funding for ongoing operations as specified in proposed §155.160(b). Others recommended a centralized approach to assessments or raised concerns about specific approaches for generating revenue, such as a provider or general tax. A few commenters requested that HHS provide technical assistance to States in developing assessment structures.

Response: Exchange flexibility in funding ongoing operations is critical, as we believe that the ability to pursue specific funding strategies may vary by State. We encourage Exchanges to consider the implications of various fee structures on all stakeholders before making a selection, but note that the Exchange has discretion to set parameters related to assessments. As we have noted previously, HHS is committed to working with States on a variety of Exchange features, including but not limited to financial sustainability.

Comment: In response to the reference to the definition of "participating issuer" in proposed §156.50, many commenters made recommendations regarding the types of issuers that should be subject to any assessments established by the Exchange. The majority of commenters advocated for a broad-based approach in which all issuers would be subject to the assessment. Fewer commenters recommended a narrower approach or that certain plans, such as excepted benefit plans, be excluded. Finally, several commenters requested that the final rule clarify that Exchanges will identify the issuers subject to any assessment.

Response: The Exchange should identify the issuers that are subject to any user fees or other assessments, if applicable. This could include all participating issuers, as defined in §156.50 of this final rule, or a subset of issuers identified by the Exchange. Similarly, an Exchange could exempt certain issuers from assessments. We believe that Exchange discretion is

important with respect to issuer participation so that Exchanges can consider a broad range of user fee and assessment alternatives. We anticipate that Exchanges will consider a variety of factors, such as the projected operating costs of the Exchange, and the number of issuers and consumers who are expected to participate, if and when establishing a fee structure.

Comment: A few commenters expressed concern that user fees or assessments charged in accordance with proposed §155.160 will be shifted to consumers and providers. These commenters variously recommended that any user fees passed on to the consumer be treated as rate increases, that user fees be reported separately on consumer bills, and that the final rule prohibit direct assessments on consumers. Conversely, several commenters recommended that the Exchange must report on user fees and other assessments; specifically, the amount collected and how the fees were used.

Response: Any user fees or other assessments collected by the Exchange would be reflected in issuers' premiums, consistent with current industry practice, and would thus be considered as part of any rate review conducted by the State. We believe that having issuers report separately any user fees is unnecessary, as we expect that the Exchange will announce user fees in advance of each plan year. With respect to having Exchanges report on user fees, we recognize that transparency is important, but defer to State flexibility to establish a process to notify issuers and report on the assessment of user fees, if this is the approach taken to supporting continued operations. We encourage States to be transparent in this process.

Comment: A handful of commenters on proposed §155.160 recommended that Exchanges establish uniform user fees for issuers in the individual Exchange and SHOP.

Response: We believe that the decision about whether to charge uniform user fees for issuers in the individual and small group markets is best made by the Exchange, within the

context of the local market and the Exchange operational structure. Therefore, we are not limiting Exchange flexibility in this area.

Comment: A few commenters on proposed §155.160(b) requested that HHS clarify the statement in the proposed rule that no Federal funds will be available to Exchanges after 2014. A few other commenters suggested that Exchanges secure funding from State Medicaid and CHIP agencies to support functions performed on behalf of individuals eligible for Medicaid and CHIP (for example, eligibility screenings and referrals).

Response: The Affordable Care Act specifies that the State ensure that its Exchange is self-sustaining by January 1, 2015. Further, as noted in the Department's State Exchange Implementation Questions and Answers released on November 29, 2011, section 1311 grant funding to establish an Exchange will only be awarded through 2014. This funding is available to States pursuing State-based Exchanges, or preparing to partner with HHS on specific functions, and can be used to fund State activities to establish Exchange functions and operating systems and to test and improve systems and processes over time. In addition, we note that nothing in this final rule prohibits an Exchange from executing agreements with other State agencies to provide funding for certain functions that also assist or support those other State agencies. As noted in the November 29, 2011 Q&A document, HHS has provided additional help to States to build and maintain a shared eligibility service that allows for the Exchange, the Medicaid agency, and the CHIP agency to share common components, technologies, and processes to evaluate applications for insurance affordability programs. This includes enhanced funding under Medicaid and opportunities for other State programs to reuse the information technology infrastructure without having to contribute funding for development costs related to shared services.

Comment: Several commenters on proposed §155.160 made recommendations with

respect to how user fees or other assessments collected by the Exchange should be incorporated into issuers' medical loss ratios. Some commenters suggested that user fees should be treated as administrative costs, while others recommended that user fees be excluded from the calculation.

Response: We clarify that all calculations and reporting of user fees must be consistent with HHS's medical loss ratio rule, published at 45 CFR 158.

Summary of Regulatory Changes

We are finalizing the provisions in proposed §155.160, with limited exceptions: first, in revised paragraph (b)(1), we consolidated the description of how Exchange revenue may be generated to simplify the regulatory language. We deleted proposed paragraph (b)(3) and instead clarified in revised paragraph (b)(2) that no Federal grant funding to establish an Exchange will be awarded after January 1, 2015. Finally, we removed the proposal that an Exchange announce user fees in advance of the plan year and instead defer to State notification processes for assessing user fees, if applicable.

<HD3>3. Subpart C - General Functions of an Exchange

Subpart C outlines the minimum functions of an Exchange, with cross-references in some cases to more detailed standards that are described in subsequent subparts (specifically, subparts D, E, H and K). The minimum functions are designed to provide State flexibility. Uniform standards are established where specified by the statute or where there were compelling practical, efficiency or consumer protection reasons. This subpart also outlines standards for consumer tools and assistance, including the Internet Web site to facilitate consumer comparison of QHPs, the Navigator program, notices, the involvement of agents and brokers, premium payment, and privacy and security.

a. Functions of an Exchange (§155.200)

We proposed that an Exchange must perform the minimum functions outlined in subparts E, H, and K related to enrollment, SHOP, and QHP certification, respectively. We also proposed that the Exchange grant certifications of exemptions from the individual responsibility requirement. The proposed rule established that each Exchange would perform eligibility determinations; establish a process for appeals of eligibility determinations; perform functions related to oversight and financial integrity; 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. We invited comments regarding these and other functions that should be performed by an Exchange.

Comment: Several commenters suggested that HHS establish objective and public performance measures to determine how well an Exchange is executing the minimum functions. Examples provided by commenters include monitoring the percent of consumers enrolled in a QHP in a timely fashion, or monitoring the change in premiums over time in relation to health plans offered outside of an Exchange. Other commenters suggested that performance should be measured against benchmarks that change over time. The commenters further suggested that HHS employ remedies to address any State-based Exchange that is not performing the minimum functions adequately, particularly the processing of applications for advance payments of the premium tax credit and cost-sharing reductions.

Response: Ongoing compliance with regulatory standards is critical to the effective operation of Exchanges and HHS is currently exploring mechanisms for performance measures and oversight tools available under section 1313 of the Affordable Care Act. We also note that the Government Accountability Office is also directed by section 1313(b) of the Affordable Care Act to conduct a study of Exchanges, including a comparison of premiums inside and outside of

an Exchange.

Comment: Several commenters urged HHS to clarify that the minimum functions in proposed §155.200 are a floor and not a ceiling. Similarly, some commenters suggested other minimum functions, including but not limited to: coordinating with public programs and entities; monitoring and addressing adverse selection; creating ombudsman office to handle complaints and appeals related to Exchange functions; and minimizing wrongful denials of eligibility.

Response: The minimum functions presented in §155.200 represent a floor that can be exceeded by an Exchange, but we do not believe we need to revise our proposed regulation text for that clarification. In response to the specific functions suggested by commenters, we believe that many of the suggested additional minimum functions are already encompassed in the final rule. For example, subpart D addresses coordination with other public programs and entities as well as the accuracy of eligibility determinations. We also note that subpart K of this part equips the Exchange with the ability to establish certification standards that mitigate adverse selection, while other sections of this subpart outlines various forms of consumer support.

Comment: A number of commenters suggested that the final rule include the standard to fulfill the United States' Trust Responsibility to provide health care for American Indian/Alaska Native individuals regardless of where they reside.

Response: We believe Congress has acknowledged the Federal government's historical and unique legal relationship with Indian tribes by providing additional benefits for American Indians and Alaska Natives to increase access to health care coverage in rural and urban areas. Those benefits include the waiver of cost-sharing amounts and the special enrollment period. We believe that the provisions in this final rule implementing these benefits will supplement the services and benefits that are provided by the Indian Health Service.

Comment: Numerous commenters recommended standards related to the certificates of exemption described in §155.200(b) of the proposed rule.

Response: As noted in the preamble to the proposed rule, we intend to address certificates of exemption and implement section 1311(d)(4)(H) and 1411 of the Affordable Care Act through future rulemaking.

Comment: Many commenters urged HHS to provide more details on the eligibility appeals minimum function in §155.200(d) of the proposed rule, and several specifically commented on the need for appeals processes to accommodate limited English proficient individuals.

Response: As noted in the preamble to the proposed rule, we intend to address the content and manner of appeals of individual eligibility determinations in future rulemaking. We have removed this from the list of minimum functions at this time. We note, however, that §155.355 provides that Exchange eligibility notices include notice of the right to an appeal. In addition, Exchange notices must meet certain minimum standards in §155.230. Both of these provisions are discussed in more detail in response to comments on those specific sections.

Comment: Many commenters urged HHS to provide more details on the standards for oversight and financial integrity of an Exchange in §155.200(e) of the proposed rule.

Response: Section 1313 of the Affordable Care Act describes the steps the Secretary may take to oversee Exchanges and ensure their financial integrity, including conducting investigations and annual audits and partially rescinding Federal financial support from a State in which the Exchange has engaged in serious misconduct. We may publish regulations or other guidance in the future describing specific parameters of this oversight.

Comment: Several commenters submitted comments in response to our proposals in §155.200(f) supporting the use of national quality standards, State flexibility in implementation, reporting quality information to consumers and the evaluation of Exchanges as well as QHPs.

Response: As noted in the preamble to the proposed rule, we intend to address the content and manner of quality reporting under this section in future rulemaking. In addition, the State Exchange Implementation Question and Answers published by HHS on November 29, 2011 discusses the implementation of the quality rating system for QHPs at question 11.

Comment: Some commenters requested clarification on whether an Exchange is considered a business associate under HIPAA.

Response: In response to commenters' requests for clarification regarding Exchanges and HIPAA, we have added language to section §155.200 clarifying the relationship between Exchanges and QHP issuers, which are HIPAA covered entities, to help States determine the applicability of HIPAA to their Exchange. The final rule provides States with a breadth of options for designing and implementing Exchange functions and operations. Therefore, it is not possible to state the applicability of the HIPAA Privacy and Security Rules to all Exchanges. We have added §155.200(e) to clarify that an Exchange is not acting on behalf of a QHP when the Exchange engages in the minimum functions outlined in this final rule.

Because the Exchange, in performing functions under §155.200, is not operating on behalf of a particular QHP issuer, but rather is acting on its own behalf in performing statutorily-required responsibilities to determine an individual's eligibility for enrollment in a QHP through the Exchange, it is not a HIPAA business associate of the QHP issuer in regard to its performance of these functions. However, an Exchange that chooses to perform functions other than or in addition to those in §155.200 may be a HIPAA covered entity or business

associate. For instance, a State may need to consider whether the Exchange performs eligibility assessments for Medicaid and CHIP, based on MAGI, or conducts eligibility determinations for Medicaid and CHIP as described in §155.302(b).

As stated in the Exchange establishment proposed rule, each Exchange should engage in an analysis of its functions and operations to determine whether the Exchange is a covered entity or business associate, based on the definitions in 45 CFR 160.103. However, we believe that clarifying our conceptualization of the relationship between an Exchange and QHP issuers will assist Exchanges in their independent evaluation of the applicability of HIPAA. Please see further discussion of privacy and security in §155.260.

Summary of Regulatory Changes

In the final rule, we made the following changes to §155.200: we have removed the proposed paragraph (c), and instead included eligibility determinations as a minimum function through reference to subpart D in paragraph (a). We have also removed the proposed paragraph (d) related to appeals of eligibility determinations. In the final rule, paragraphs (c) and (d) now reflect the minimum functions related to oversight/financial integrity and quality activities, respectively. We have added a new paragraph (e) to clarify our intent that in carrying out its responsibilities under subpart C, an Exchange would not be considered to be operating on behalf of a QHP.

b. Partnership

In the Exchange establishment proposed rule, HHS introduced the concept of a Partnership model in which HHS and States work together on the operation of an Exchange. At a State grantee meeting on September 19, 2011, HHS provided additional information regarding the Partnership model.

A Partnership Exchange would be a variation of a Federally-facilitated Exchange. Section 1321(c) of the Affordable Care Act establishes that if a State does not have an approved Exchange, then HHS must establish an Exchange in that State; the statute does not authorize divided authority or responsibility. This means that HHS would have ultimate responsibility for and authority over the Partnership Exchange. In a Partnership Exchange, we intend to provide opportunities for a State to help operate the plan management function, some consumer assistance functions, or both. For successful operation of the Exchange in this model, we expect that States would agree under the terms of section 1311 grants to ensure cooperation from the State's insurance, Medicaid, and CHIP agencies to coordinate business processes, systems, data/information, and enforcement. Under such an arrangement, States could use section 1311 Exchange grant funding to pay for activities related to establishment of these Exchange functions, thereby maintaining existing relationships and allowing for easier transitions to State-based Exchanges in future years if a State elects to pursue Exchange approval.

Comment: Many commenters supported the goal of a Partnership, but voiced concerns about the potentially negative implications for a seamless consumer experience. Commenters urged HHS to ensure that consumers would not be able to differentiate an Exchange operated by a single entity from a Partnership Exchange. Other commenters recommended a highly transparent process so consumers would know where to file appeals and voice complaints and health insurance issuers would know which standards are enforced by which entity. Some commenters raised concerns about separating Exchange functionality at all, and urged HHS not to sacrifice a seamless consumer experience for State flexibility.

Response: A seamless consumer experience is a cornerstone to an effective Exchange, and we plan to structure any Partnership in such a way that will not undermine a smooth process for individuals and employers.

Comment: Several commenters suggested other functions for State involvement in a Partnership instead of the plan management and consumer assistance, in particular suggesting that States perform Medicaid eligibility determinations. Some commenters recommended allowing a State to retain responsibility for making Medicaid eligibility determinations in order to avoid duplicating existing State systems or curtailing traditional State responsibilities. A few commenters suggested that there be specific process to handle disputes between HHS and Medicaid regarding Medicaid eligibility if States retained that function in a Federally-facilitated Exchange, and one suggested that consumers be held harmless and enrolled in coverage during eligibility disputes. Meanwhile, other commenters urged HHS not to bifurcate eligibility determinations between Federal and State entities out of concerns about the negative implications for the consumer experience and the complications such bifurcation would create. A small number also suggested that a State with a Federally-facilitated Exchange must accept Federal eligibility determinations.

Other proposed functions for Partnership included: the certificates of exemption described in §155.200(b), quality rating system, enrollee satisfaction tools, determination of affordability and minimum value of employer-sponsored coverage, or eligibility determinations for advance payments of the premium tax credit. Other commenters suggested areas that should specifically be retained by a State in any circumstance, including State responsibility for overseeing licensure, solvency, market conduct, form approval and other operations of QHPs, overseeing licensed agents, and responding to consumer complaints.

Response: In this final rule, we address leveraging existing State resources and expertise regarding Medicaid in subpart D. Exchange responsibilities related to the quality rating system and enrollee satisfaction survey will be outlined in future rulemaking. In addition, HHS continues to explore how to leverage existing State insurance activities in several areas, including licensure, solvency, and network adequacy. The State Exchange Implementation Questions and Answers published on November 29, 2011 provide additional discussion in this area.

Comment: Some commenters suggested that we allow States to have a variety of options under a Partnership Exchange, while other commenters recommended that a standardized set of limited options would be the most effective way to ensure that a Partnership does not create significant administrative burden.

Response: We recognize that an unlimited number of options for organization of a Federally-facilitated Exchange would be extremely complicated to implement and operate, and believe that the options and flexibilities HHS has laid out will balance flexibility with administrative feasibility.

Comment: Many commenters, citing concerns about accountability, supported the approach of the Partnership being a form of a Federally-facilitated Exchange, while others preferred that States retain ultimate authority in a Partnership. Some of the commenters urged HHS to oppose any Partnership that would confuse or blur lines of authority and responsibility. A few commenters suggested that HHS have readiness assessments or performance metrics to measure how a State will perform, or is performing, a function under Partnership. One commenter suggested that HHS have no role in plan management if a State decides to operate this function, while another voiced concerns about how HHS would enforce certain decisions if a

State is operating one or more Exchange functions.

Response: Section 1321(c) of the Affordable Care Act does not contemplate divided authority over an Exchange. In all organizations of a Federally-facilitated Exchange, the Secretary will retain ultimate responsibility and authority over operations and all inherently governmental functions. A State wishing to enter into a Partnership must agree to perform the function(s) within certain parameters, as agreed upon by the State and HHS.

Comment: Some commenters urged HHS not to allow a State to operate only an individual market or SHOP component of an Exchange through a Partnership.

Response: We believe that splitting the SHOP through a Partnership is not a reasonable or feasible option at this time and have not established that as an option.

Comment: Many commenters urged HHS to consult with stakeholders during the development of a Partnership with a given State.

Response: Section 155.105(f) clarifies that the Federally-facilitated Exchange must follow the stakeholder consultation standards in §155.130. The Federally-facilitated Exchange will consult with a variety of stakeholders to ensure that the needs of the States in which it operates are met.

Comment: A few commenters requested that Tribal governments be eligible to participate in a Partnership.

Response: Currently, only States would be eligible to enter into a Partnership with HHS, as States are the entities designated in the Affordable Care Act as responsible for setting up an Exchange (see discussion of the Exchange establishment proposed rule for more detail (76 FR 41870). However, HHS will continue ongoing tribal consultation to ensure that Exchanges address the needs of tribal populations.

Summary of Regulatory Changes

We did not propose regulations on Partnership and have not added any in this final rule. Rather, further information will be provided in the context of future guidance on the Federally-facilitated Exchange.

c. Consumer assistance tools and programs of an Exchange (§155.205)

In proposed §155.205, we established that the Exchange must provide for the operation of a consumer assistance call center that is accessible via a toll-free telephone number, and outlined capabilities and suggested infrastructure as well as types of information we think will be most critical to consumer experience and informed decision-making. The proposed rule sought comment on ways to streamline and prevent duplication of effort by the Exchange call center and QHP issuers' customer call centers while ensuring that consumers have a variety of ways to learn about their coverage options and receive assistance.

We further proposed that an Exchange must maintain an Internet Web site that contains the following information on each available QHP: the premium and cost sharing information; the summary of benefits under section 2715 of the PHS Act; the identification of the QHP coverage ("metal") level; the results of the enrollee satisfaction survey; the assigned quality ratings; the medical loss ratio; the transparency of coverage measures reported to the Exchange, and the provider directory.

We noted that we were evaluating the extent to which the Exchange Web site may satisfy the need to provide plan comparison functionality using HealthCare.gov, and invited comment on this issue. We also requested comment on a Web site standard that would allow applicants, enrollees, and individuals assisting them to store and access their personal account information and make changes.

We also proposed that the Exchange Web site be accessible to persons with disabilities and provide meaningful access to persons with limited English proficiency. In addition, we proposed that the Exchange post certain QHP financial information, and that an Exchange establish an electronic calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of any advance payments of the premium tax credit and cost-sharing reductions. We invited comment on the extent to which States would benefit from a model calculator and suggestions on its design.

Finally, we proposed that the Exchange have a consumer assistance function, and that the Exchange conduct outreach and education activities to educate consumers about the Exchange and encourage participation separate from the implementation of a Navigator program described in §155.210.

Comment: Several commenters supported the significant flexibility in structuring a call center provided in proposed §155.205(a). Other commenters suggested that HHS establish more detailed standards such as establishing key areas of competency for a call center service, including being able to provide information about QHPs, the categories of available assistance, and the application process. Some commenters recommended that an Exchange call center address additional topics, ranging from the ability to make appropriate referrals to other sources of information, to the capacity to provide enrollment assistance to hospitals and other providers encountering the uninsured. One commenter said that the call center should be able to respond to online chat.

Response: We accept the recommendation of commenters that Exchange discretion in establishing a call center should be maintained, and therefore have not established additional standards in §155.205(a) of the final rule. The final rule does not preclude an Exchange from

adopting additional standards or implementing the specific suggestions from commenters to provide more robust consumer assistance.

Comment: HHS received many comments regarding an Exchange's ability to make appropriate referrals through the call center in proposed §155.205(a). Commenters specifically recommended that Exchanges have the capacity to refer consumers to Medicaid, Indian Health Service/Tribal/Urban (I/T/U) providers, Navigators and assisters, oral translation services, and family planning services. A commenter also suggested that the call center be able to appropriately address the special issues facing families with mixed immigration status. Several commenters asked that the call center refer consumers who were ineligible for coverage through the Exchange to safety net health providers and other low-cost, non-Exchange options. Some commenters suggested that the call center be able to appropriately refer discrimination complaints.

Response: We believe §155.205(a) addresses this issue with the phrase "address the needs of consumers requesting assistance." In the preamble to the proposed rule, we noted that the Exchange call center should be a conduit to services like Navigators and State consumer programs (76 FR 41875). We maintain this expectation under this final rule and note that Exchanges have discretion to establish more specific standards.

Comment: Many commenters recommended that the call center be able to provide oral communication to people with limited English proficiency (LEP), and several suggested standards that assure service to those with hearing disabilities.

Response: We have amended the final rule to apply the meaningful access standards specified in the redesignated §155.205(c)(1), (c)(2)(i), and (c)(3) to an Exchange call center. HHS will also issue further guidance on language access and such guidance will coordinate our

accessibility standards with insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services and access standards.

Comment: HHS received comments about ways a call center can assure quality service, including training on important topics, establishing performance standards on topics like call wait times, abandonment rates, and call return time; or modeling call center performance standards on existing call centers, with 1-800 Medicare and the Michigan Health Insurance Consumer Assistance Program mentioned as positive examples. Commenters also suggested testing the call center with consumer focus groups, developing analytics on call center service issues, and updating an Exchange customer's account with a record of any services provided by call center personnel.

Response: We believe that §155.205(a) as proposed outlines general standards to address the needs of consumers and we retain this language in the final rule. We did not propose and are not adding specific performance standards for Exchange call centers in this final rule, but we note that in connection with the operation of Federally-facilitated Exchanges, we will take these specific performance recommendations into consideration.

Comment: HHS received many comments on the need to coordinate call center services with other entities. Several commenters recommended that service issues handled by an Exchange call center versus those handled by a QHP issuer call center should be clearly delineated to avoid consumer confusion and unnecessary duplication, a topic for which we requested comment in the proposed rule. One commenter recommended limiting the Exchange call center services to pre-enrollment, leaving QHP issuers to provide customer service for QHP enrollees. Another commenter recommended a "no wrong number" approach to customer

service, advising that State flexibility would best foster a solution. One commenter spoke of the need to integrate the call center with the Exchange Web site in order to provide personal service without having callers repeat information already entered via an online account. Another commenter asked that HHS clarify the different roles of eligibility workers and the call center.

Response: An Exchange must balance the need to prevent duplication against ensuring that consumers have a variety of ways to learn about their coverage options, an imperative supported by the flexibility in paragraph §155.200(a). In regard to the differing roles between eligibility workers and the call center, we believe this is an operational issue that each Exchange must address. Thus, we are finalizing this provision as proposed.

Comment: Related to proposed §155.200(b), many commenters remarked that the Web site www.Healthcare.gov's "Find Insurance Options" would work as a model for health plan comparison for the Exchange, though often with the caveat that this feature should be fully integrated into the Exchange Web site. A commenter also noted that Healthcare.gov provides a foundation but would need changes to be used for an Exchange. Some commenters opposed Healthcare.gov as a model because it does not have transactional functionality or a precise premium calculator. Another commenter urged HHS to also consider eHealthInsurance.com and Medicare.gov as models.

Response: HHS considered comments on the appropriateness of Healthcare.gov as a model for presenting comparative plan information, as well as comments suggesting consulting other models such as eHealthInsurance.com and Medicare.gov. We will take these recommendations into account in development of the model Internet Web site template and in future guidance.

Comment: With respect to the preamble discussion related to proposed §155.205(b),

commenters were generally supportive of the concept that Exchange Web sites allow applicants and enrollees to store and access their personal information in an online account or allow eligibility and enrollment application assisters to maintain records of an individual's application process. Some commenters raised privacy and security concerns, and one commenter suggested applying a privacy and security standard like that used by the Financial Industry Regulatory Authority (FINRA) in its self-regulation of the securities industry, ensuring that actions by authorized representatives are recorded for consumer protection purposes.

Response: We believe that applicants, enrollees, and authorized third party assisters should have access to an online personal account with strong privacy and security protections and will consider these comments when developing the model Internet Web site template and guidance. We encourage Exchanges to consider the benefit of accounts, but are not establishing account functionality as a minimum Exchange Web site standard in this final rule.

Comment: Many commenters supported the proposal in §155.205(b)(1)(ii) that the Exchange display the summary of benefits and coverage established in section 2715 of the PHS Act. Several noted that the summary of benefits should be searchable, not necessitate additional software to view, and include drug formulary information.

Response: Enrollees, consumers, and other stakeholders need access to a variety of cost and benefit information via the Exchange Web site to make an informed plan selection. Accordingly, we are finalizing the provisions in paragraphs §155.205(b)(1)(i) and (ii), which direct an Exchange Web site to display premium and cost-sharing information and a summary of benefits and coverage for each QHP. We clarify that paragraphs (b)(1)(i) and (b)(1)(ii) are separate standards because the premium and cost-sharing information needs for an Exchange surpass those included in the summary of benefits and coverage document. We note that

paragraph (b)(1)(ii) allows an Exchange the option of collecting the summary of benefits from issuers in a manner supporting a searchable format. The content of the summary of benefits and coverage is outside of the scope of this final rule and refer readers to the Summary of Benefits and Coverage and Uniform Glossary final rule, codified at §147.200 of this title, published at 77 FR 8668 (Feb. 14, 2012).

Comment: With respect to the provider directory standard in proposed §155.205(b)(1)(viii), a number of commenters recommended that an Exchange provide an up-to-date consolidated provider directory to enable consumers to see which QHPs a given provider participates in from the Exchange Web site. A few other commenters advised HHS to ensure that the Exchange link to a QHP's Web site provider directory for timely and accurate information. Another commenter asked that the final rule clarify that an online directory meets the standard in paragraph (b)(1)(viii), and that Exchanges do not need to provide paper provider directories.

Response: HHS considered the comments received on the Internet Web site's display of provider directory information. To maintain maximum flexibility for an Exchange, the final rule does not specify whether an Exchange should collect a consolidated provider directory or link to a QHP's Web site in order to meet the standards in paragraph (b)(1)(viii). Additional comments on the provider directories are addressed in §156.230.

Comment: One commenter indicated that our proposed standard in §155.205(b)(1)(vi) to display medical loss ratio on the Exchange Web site was inappropriate, comparing it to a manufacturer's cost to produce. Another commenter suggested dropping the proposed MLR display for the individual market Exchange, stating that it was too technical a concept to be useful for consumers.

Response: Issuers are already report this data under the Affordable Care Act in

accordance with section 2718 of the PHS Act, and displaying the medical loss ratio on the Exchange Web site makes this information accessible to consumers.

Comment: Several commenters noted that an Exchange should track which Web site features were most used, or caused consumers difficulty, in order to continually improve the Web site. Some of these commenters asked that usage information be publicly disclosed.

Response: Statistics on Web site usage may be helpful for Exchange quality assurance, and we will consider these comments when developing best practice guidelines for Exchanges. We make no modifications in the final rule to specifically regulate collection or dissemination of statistics on Web site usage.

Comment: Many commenters supported the proposed §155.205(b)(2) standards regarding meaningful access to people with disabilities and persons with limited English proficiency, with some suggesting that HHS further clarify that the Web site must be fully accessible, with Web site materials and notices available in alternative formats. One commenter noted that the Exchange calculator and other online tools should be accessible and independently usable as much as possible for people with disabilities. Commenters suggested that all Web site language be at a sixth grade proficiency level. A number of commenters suggested that the Web site be available in Spanish and one or more languages prevalent in the Exchange service area. Many suggested that the Web site clearly display taglines in up to 15 different languages explaining how to access oral translation in those languages. In contrast, one commenter requested that HHS defer to a State on meaningful access standards because a State is best situated to determine local needs. Finally, several commenters suggested that meaningful access standards apply to information presented on the Web site on premiums, premium tax credits, individual responsibility exemptions, and the appeals process.

Response: We have made several changes in this final rule. We added paragraph §155.205(c) to establish that communications be in plain language to help applicants and enrollees understand the information presented; the definition of "plain language" is discussed in §155.20 of this final rule. We added §155.205(c)(1) to specify that auxiliary aids and services be provided at no cost to the individual. Provisions on access for those with limited English proficiency are modified in new paragraph §155.205(c)(2) to include oral translation, written translation, and taglines in non-English languages indicating the availability of language services. Finally, we added paragraph (c)(3) to establish that the Exchange must inform applicants and enrollees of the services in paragraph (1) and (2). We note that in this final rule, at §155.230(b) and §156.250, we apply the meaningful access standards to Exchange notices and QHP issuer notices, respectively. We note that the standards in this section do not preempt current guidance issued by the Office of Civil Rights.

We are not adding specific accessibility standards in this final rule, but intend to issue such standards in future guidance, seeking input first from States and other stakeholders about appropriate standards. Such guidance will coordinate our accessibility standards with insurance affordability programs, and across HHS programs, as appropriate, providing more detail regarding literacy levels, language services and access standards.

We retained the standard that Web sites must be accessible to people with disabilities and encourage States to review WCAG 2.0 level AA Web site standards, which have been considered for adoption as Section 508 standards in the recent proposed rule issued by the Architectural and Transportation Barriers Compliance Board (Access Board)76 FR 76640, December 8, 2011). See also Section 5.1.3 of the Guidance for Exchange and Medicaid

Information Technology (IT) Systems 1.0 published in November 2010[2]. We intend to publish future guidance on these standards.

Comment: With respect to the financial information described in proposed §155.205(b)(3)(i), one commenter sought clarification on what HHS means by licensing costs. Another commenter recommended dropping the proposal in §155.205(b)(3)(v) that Exchanges display losses due to waste, fraud and abuse, arguing that it would be speculative and inflammatory. Alternatively, several other commenters asked for more detail on Exchange reporting, and asked that HHS direct an Exchange to include all costs, including costs incurred in making a Medicaid eligibility determination, in the administrative cost of the Exchange.

Response: We did not accept the recommendations to establish additional standards and have maintained the proposed policy in the final rule, which is redesignated as subparagraph (b)(6). Section 1311(d)(7) of the Affordable Care Act directs the Exchange Web site to display losses due to waste, fraud and abuse. HHS will consider the request for greater clarity on licensing costs as we develop guidance to interpret and implement this standard.

Comment: Many commenters supported our proposal that the Exchange Web site provide information about Navigators and other assisters in §155.205(b)(4). Several commenters suggested that HHS explicitly include the display of contact information for other assisters, especially the Exchange call center. Another commenter asked that brokers and agents only be listed if they are also Navigators. One tribal entity remarked that consumer assistance should include services provided by Indian Health Service/Tribal/Urban (I/T/U) organizations.

Response: We maintain the standard in redesignated §155.205(b)(3) of this final rule. Exchanges have the flexibility to establish additional standards regarding posting information

[2] Guidance for Exchange and Medicaid Information Technology (IT) Systems 1.0 published in November 2010: http://cciio.cms.gov/resources/files/joint_cms_ociio_guidance.pdf.

relating to Navigators and other assisters.

Comment: Many commenters were supportive of a Exchange Web site that facilitates a "one-stop" eligibility determination as described in §155.205(b)(5) of the proposed rule. Commenters were supportive of the Web site allowing for enrollment in coverage. Another commenter stated that the Exchange should not be the only access point for coverage, and that HHS should address the need for consumer assistance for Web site-related purchasing mistakes.

Response: Exchange Web sites will not be the only access point for an individual to apply for coverage through the Exchange. Standards for enrollment initiated by an applicant through a non-Exchange Web site are described in an amended §155.220 and §156.265, which provide additional details about eligibility determinations and protections against an applicant's personal data from being inappropriately shared with other parties. Applications are also described in §155.405(c) of the final rule. We have also modified the Web site's function in enrollment in the proposed §155.205(b)(1), by clarifying in redesignated §155.205(b)(5) that an Exchange Web site facilitates the selection of a QHP by a qualified individual since enrollment is effectuated by the QHP issuer in a process described in §156.265(b).

Comment: Many commenters expressed support for a Web site calculator proposed in §155.205(c) that displays the estimated cost of coverage after the application of any expected advance payments of the premium tax credit and cost-sharing reductions. In general, these commenters urged simplicity and requested no additional calculation from the consumer. Several commenters recommended that HHS provide a national model calculator for efficiency and consistency across Exchanges. One commenter in particular asked that the calculator make cost-sharing reductions available to American Indians/Alaska Natives readily apparent. Another commenter suggested that the Web site provide a standard way for a consumer to take less than

the available advance payment of the premium tax credit. A few other commenters suggested that the Web site have decision support to help a consumer see how a change in income would affect advance payments of the premium tax credit and make a plan selection accordingly. Several commenters suggested that the Exchange specify that an "out-of-pocket" estimate be part of the Exchange calculator in order to help consumers avoid evaluating cost by premium alone. Finally, one commenter suggested that the calculator account for the variation in cost sharing for "in-network" versus "out-of-network" services.

Response: We will consider these recommendations as we develop guidance, best practices, and the model Web site template, but we are not finalizing more specific standards for the electronic calculator in this final rule as we are codifying the statutory provision related to the calculator.

Comment: Commenters were generally supportive of Exchanges providing consumer assistance as described in §155.205(d) of the proposed rule. Many asked that an Exchange complete a consumer needs assessment before designing its consumer assistance program. HHS received many comments on the need to conduct outreach and education for hard to reach populations described in proposed §155.205(e). Many commenters remarked that assistance should be able to serve those with disabilities or limited English proficiency, suggesting standards for consumer assistance such as oral translation for all limited English proficient individuals, or simply that such services be culturally and linguistically appropriate. Some commented that consumer assistance workers should be knowledgeable of the Indian Health System. One commenter remarked that consumer assistance should be accessible across multiple channels, including Web site, telephone, and in-person. Several commenters remarked on the need for in-person assistance, with one commenter suggesting the Internal Revenue Service's

Volunteer Income Tax Assistance Program as a model, another commenter recommending agents and brokers for consumer assistance, and a third suggesting that assistance be provided as much as possible by nonprofit organizations. Others suggested that an outreach program be coordinated with public programs because of the likely overlap in eligibility, or with providers like Federally Qualified Health Centers and essential community providers. Other commenters pointed to existing enrollment campaigns for lessons learned, such as the need to build in time to "ramp up" an enrollment campaign.

Response: We will consider comments we received on consumer assistance in §155.205(d) in the development of guidance. In this final rule, we maintain this provision as proposed and believe that it provides sufficient discretion to further develop the consumer assistance function. We have modified §155.205(e) in this final rule to direct Exchanges to provide education regarding insurance affordability programs to ensure coordination with public programs. HHS received many helpful comments on how to ensure effective consumer assistance and outreach and will consider these as we develop guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.205 of the proposed rule, with the following modifications: we renumbered proposed paragraphs (b)(3) through (b)(6) as (b)(2) to (b)(5) in the final rule. We clarified in paragraph (b)(5) of this final rule that a qualified individual may select a QHP on the Exchange Web site to initiate the enrollment process, rather than completing the entirety of the enrollment process on the Web site. We moved the standard regarding the calculator to paragraph (b)(6) of this final rule. We redesignated paragraph (c)(1) and clarified standards for persons with disabilities, including the provision of auxiliary aids and services at no cost to the individual and that Exchange Web sites must be accessible. We added

paragraph (c)(2) to outline standards for limited English proficient persons, including that oral translation be available, written translation be available, and that the availability of language services be displayed with taglines written in each respective language, and in paragraph (c)(3) that individuals must be made aware of the availability of these services. Finally, we made several minor technical and non-substantive changes.

d. Navigator program standards (§155.210)

In §155.210, we proposed Navigator program standards for both the individual market Exchange and SHOP. We first proposed that Exchanges must award grant funds to public or private entities or individuals to serve as Navigators, and described the eligibility standards for and the types of entities to which the Exchange may award Navigator grants. We also identified the minimum duties of Navigators, including standards for the information and services provided by Navigators. We sought comment on how best to ensure that the information provided by Navigators is accurate and complete and whether HHS should identify additional standards for Navigators in future guidance.

We further proposed that a Navigator must meet any licensing, certification or other standards prescribed by the State or Exchange, as appropriate, and may not have a conflict of interest during the term as Navigator. We sought comment on whether we should propose additional standards on Exchanges to make determinations regarding conflicts of interest.

In addition, we proposed that the Exchange include at least two types of Navigators from the list of eligible entities included in the Affordable Care Act. We sought comment as to whether we should ensure that at least one community and consumer-focused non-profit organization be designated as a Navigator by an Exchange, or whether we should provide that Navigator grantees reflect a cross-section of stakeholders.

We also proposed to codify the statutory prohibitions on Navigator conduct in the Exchange, specifically that health insurance issuers are prohibited from serving as Navigators and that Navigators must not receive any compensation from any health insurance issuer in connection with the enrollment of any qualified individuals or qualified employees in a QHP. We sought comment on this issue and whether there are ways to manage any potential conflicts of interest that might arise.

Finally, we proposed to codify the statutory restriction that the Exchange cannot support the Navigator program with Federal funds received by the State for the establishment of Exchanges. For a more detailed discussion of how this statutory prohibition applies in States where Navigators address Medicaid and CHIP administrative functions, please refer to the preamble of the Exchange establishment proposed rule (76 FR 41878). We also noted that we were considering a standard that the Navigator program be operational with services available to consumers no later than the first day of the initial open enrollment period.

General Standards

Comment: Regarding proposed §155.210(a), several commenters had specific recommendations regarding the types of and content of contractual agreements that should exist between Navigators and Exchanges.

Response: The final rule does not specify the type of or contents of the contractual agreements between Exchanges and Navigators, other than codifying the statutory provision that Navigators receive grants. Exchanges can design the grant agreements as they deem appropriate so long as they ensure that Navigators are completing, at least, the minimum duties outlined in §155.210(e) of the final rule.

Comment: Several commenters recommended additional standards for Navigator

programs established under proposed §155.210(a), including a needs assessment of the population in the geographic areas in which Navigators will serve consumers and an ongoing evaluation system to gauge Navigator performance.

Response: While a needs assessment is likely to yield useful information in developing the Navigator program, we do not accept the commenters' suggestion that Navigator programs conduct such assessments. We note that many States have already begun research on the needs of the populations an Exchange could serve. To the extent that needs assessments undertaken as part of Exchange establishment and planning do not inform which types of Navigators to select and how Navigators can best serve potential Exchange enrollees, we encourage States to conduct them. But the final rule does not direct States to conduct additional research. Additionally, we strongly encourage Exchanges to implement regular reviews and assessments of their Navigators.

Comment: A significant number of commenters expressed the importance of mitigating Navigator conflict of interest and of ensuring Navigator accountability. Many commenters asked that HHS issue specific conflict of interest standards that would apply to all entities interested in serving as Navigators, and some made specific recommendations regarding what should be included in such standards. Several commenters, including consumer and patient advocacy groups and State agencies, also requested that we define "conflict of interest" as used in §155.210(b)(1)(iv) of the proposed rule, while another commenter suggested that States should have the flexibility to determine if a conflict of interest exists for Navigators.

Response: The final rule contains restrictions on Navigator conduct that are intended to eliminate possible sources of conflicts of interest. However, the baseline standards that we have specified will likely not be sufficient to comprise a robust set of conflict of interest standards in

all Exchanges. As such, §155.210(b)(1) of the final rule establishes that Exchanges develop and disseminate a set of conflict of interest standards to ensure appropriate integrity of Navigators. Exchanges will be best-equipped to determine what additional conflict of interest standards are appropriate for their markets, and we strongly urge Exchanges to develop standards that are sufficient to help ensure that consumers receive accurate and unbiased information at all times from all Navigators. We also clarify here that "conflict of interest," as used in §155.210(c)(1)(iv) of the final rule, means that a Navigator has a private or personal interest sufficient to influence, or appear to influence, the objective exercise of his or her official duties; for purposes of this rule, it includes the conflict of interest standards developed by each Exchange.

We urge Exchanges to develop conflict of interest standards that include, but are not limited to, areas such as financial considerations; non-financial considerations; the impact of a family member's employment or activities with other potentially conflicted entities; Navigator disclosures regarding existing financial and non-financial relationships with other entities; Exchange monitoring of Navigator-based enrollment patterns; legal and financial recourses for consumers that have been adversely affected by a Navigator with a conflict of interest; and applicable civil and criminal penalties for Navigators that act in a manner inconsistent with the conflict of interest standards set forth by the Exchange. Additionally, we will be releasing model conflict of interest standards in forthcoming guidance.

Comment: We requested comment on standards related to training in the proposed rule and received a large number of responses on this issue. Several commenters suggested that HHS establish minimum standards for Navigator training, including templates for the format and content of Navigator training materials. Some commenters suggested that Navigators be trained to specifically serve the needs of varying groups, including but not limited to: low-income

individuals; limited English proficient individuals; tribal organizations; individuals with disabilities; and individuals with mental health or substance abuse needs. Other commenters urged HHS to defer to States in relation to Navigator training and standards beyond those established in the proposed rule.

Response: Due in part to the sensitivity of information that will be available to Navigators, newly added §155.210(b)(2) of the final rule directs Exchanges to establish training standards that apply to all persons performing Navigator duties under the terms of a Navigator grant, including both paid and unpaid staff of entities serving as Navigators. We plan to issue training model standards in forthcoming guidance to supplement, not replace, the need for Navigator applicants to demonstrate that they can carry out the minimum duties of a Navigator as listed in §155.210(e) of the final rule. We encourage Exchanges to conduct ongoing and recurring training for Navigators.

Comment: One comment from a consumer advocacy organization requested that HHS specifically indicate that the Gramm-Leach-Bliley Act (Pub. L. 106-102) does not apply to the Navigator program as Navigators will not be selling insurance.

Response: The Gramm-Leach-Bliley Act (GLBA) is intended to enhance competition in the financial services industry by providing a prudential framework for the affiliation of banks, securities firms, insurance companies, and other financial service providers, and for other purposes. To the extent a Navigator is not licensed to sell insurance, we believe the GLBA would not apply. The GLBA will apply to agents and brokers as it currently does, including agents and brokers that choose to serve as Navigators. However, other Navigator grantees will not be affected. Navigators must meet other training, conflict of interest, and privacy and security standards established by the Exchange.

Comment: We received many comments expressing support for a standard that Navigator programs be operational with services available to consumers no later than the first day of the initial open enrollment period. Some commenters noted that while they support the proposed start date, they prefer an earlier operational start date.

Response: We have not directed Navigator programs to be operational by the first day of the initial open enrollment period. However, we encourage Navigator programs to be operational with services available to consumers by October 1, 2013, for State-based Exchanges that are approved or conditionally approved by January 1, 2013, or the start of any annual open enrollment period in subsequent years for State-based Exchanges certified after January 1, 2013.

Entities Eligible to be a Navigator

Comment: Many commenters proposed that States, Exchanges, or HHS should set appropriate certification or licensing standards for Navigators. A few commenters proposed that HHS set a broad range of certification or licensing standards that States or Exchanges could tailor to meet their own needs, while others suggested specific programs upon which Exchanges could model Navigator certification standards, such as the Medicare State Health Insurance Assistance Programs, ombudsman programs, area agencies on aging, and Promotoras, a community health worker model that has been adopted into many Latino communities in the United States.

Response: We understand and appreciate the concerns of commenters that recommended certification or licensure standards for Navigators; we have finalized in this rule a primary role for Exchanges and States in the creation, development and enforcement of such standards. We encourage Exchanges to set certification or licensing standards for Navigators in accordance with the guidelines set forth in this final rule and any State law(s) that may apply. However, without

some minimum standards, significant variability may develop that could put consumers at a disadvantage. Therefore, HHS has added §155.210(b)(2) of the final rule to indicate that Exchanges must develop a set of training standards to ensure Navigator competency in the needs of underserved and vulnerable populations, eligibility and enrollment procedures, and the range of public programs and QHP options available through the Exchange. Additionally, given the policy set forth in §155.210(c)(1)(v) that Navigators comply with the privacy and security standards adopted by the Exchanges under §155.260, the training standards must also ensure that Navigators are trained in the proper handling of tax data and other personal information. HHS also plans to issue additional guidance on the model standards for Navigator training and best practices for certification or licensure standards.

Comment: A majority of commenters proposed that Navigators should not have to hold an agent or broker license or errors and omissions liability coverage in order to be certified or licensed as a Navigator. Conversely, a small number of commenters suggested that Navigators hold an agent or broker license as well as errors and omissions coverage and that Navigators should be subject to the same licensing and education standards established for agents and brokers.

Response: We accept the commenters' suggestion that States and Exchanges should not be able to stipulate that Navigators hold an agent or broker license, and we clarify that States or Exchanges are prohibited from adopting such a standard, including errors and omissions coverage. "Agent or broker" is defined in §155.20 as "a person or entity licensed by the State as an agent, broker, or insurance producer." Thus, establishing licensure standards for Navigators would mean that all Navigators would be agents and brokers, and would violate the standard set forth §155.210(c)(2) of the final rule that at least two types of entities must serve as Navigators.

Additionally, we do not think that holding an agent or broker license is necessary or sufficient to perform the duties of a Navigator as these licenses generally do not address training, among other things, about public coverage options.

Comment: Several commenters addressed the need for Navigators to have expertise in serving American Indian/Alaska Native communities and on the ability of Navigators to adequately address the needs of American Indians/Alaska Natives. In addition, a few commenters suggested we modify the language proposed in §155.210(b)(1)(iii) such that Navigators serving tribal communities should be exempt from any State licensing or certification standards, as well as from conflict of interest standards.

Response: Exchanges that include one or more Federally-recognized tribes within their geographic area must engage in regular and meaningful consultation and collaboration with tribes in accordance with §155.130(f) of this final rule. In section 155.210(c)(2), we have identified Tribes, Tribal organizations, and urban Indian organizations as eligible entities to serve as Navigators. Development of the Navigator program should be an important element of Exchanges' consultation with Tribal governments. The Navigator program will help ensure that American Indians/Alaska Natives participate in Exchanges.

Comment: Commenters recommended that when the geographic area of an Exchange includes an Indian Tribe, tribal organization, or Urban Indian organization, that at least one of these organizations must be included as a Navigator within this Exchange. Another commenter recommended that HHS include directives to Navigator programs and contractors to provide resources directly to Tribes so they can conduct Navigator tasks within their own communities.

Response: Although Indian Tribes, tribal organizations, or Urban Indian organizations are listed in §155.205(c)(2)(viii) as potential Navigators, we believe that the Exchange should have

flexibility regarding the granting of Navigator awards. However, as noted previously, development of the Navigator program should be a critical element of an Exchange's consultation with tribal governments, and tribal governments should have the opportunity to provide early input on the development of the Navigator program.

Comment: Several commenters articulated the need for Navigators to be non-discriminatory in performing their duties. Commenters recommended that Navigators should comply with the non-discrimination standards that apply to the Exchange as a whole.

Response: We clarify that because Navigators are third parties under agreement (that is, the grant agreement) with the Exchange, the non-discrimination standards that apply to Exchanges in §155.120(c) will also apply to entities seeking to become Navigators.

Comment: Regarding §155.205(b)(2), a majority of commenters supported the provision suggested in the proposed rule to establish that at least one of the two types of entities eligible to serve as Navigators must be a community or consumer-focused non-profit entity (76 FR 41877). Several commenters recommended expanding the list of categories to include additional entities. A small number of commenters thought States should have sole discretion over the determination of which entities may serve as Navigators. One commenter favored allowing States to determine the need for a Navigator program; another recommended using licensed insurance professionals to facilitate enrollment; and a small number stated that the standard that two types of entities must be Navigators was unnecessary and counterproductive.

Response: We accept the commenters' suggestion that at least one entity that serves as a Navigator should be a community or consumer-focused non-profit, and have amended §155.210(c)(2) to convey this policy. The categories listed in the final rule in §155.210(c)(2) represent a broad spectrum of organizations, but are not meant to be an exhaustive list of

potential Navigators. As stated in §155.210(c)(2)(viii), other public or private entities that meet the standards of the Navigator program may be eligible to receive a Navigator grant. When establishing a Navigator program, Exchanges should plan to have a sufficient number of Navigators available to assist qualified individuals and employers from various geographic areas and with varying needs who wish to enroll in QHPs within their State.

Comment: One comment stated that a Navigator should never be an individual person, but instead a verifiable and appropriately regulated entity or institution.

Response: We believe that the standard to meet licensure and certification standards in §155.210(c), and the prohibition against health insurance issuers, and those who receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment in the Exchange, from receiving Navigator grants in §155.210(d) will serve as sufficient regulation against fraud by individuals or organizations who qualify to be Navigators.

Prohibitions on Navigator Conduct

Comment: Many commenters discussed the impact that Navigator compensation, or "consideration" as used in §155.210(c)(2) of proposed rule, would have on a Navigator's obligation to provide impartial assistance and avoid conflicts of interest. The majority of these commenters recommended that Navigators be prohibited from receiving compensation from health insurance issuers for enrolling individuals in plans outside of the Exchange, while some commenters expressed support for the compensation restrictions as proposed. Several commenters requested that a prohibition on enrollment-based compensation from a health issuer not prohibit Navigator programs from utilizing Medicaid or CHIP funds for appropriate Navigator activities. Some commenters also recommended that such a prohibition not preclude Navigators from receiving grants from health insurance issuers for activities unrelated to

enrolling individuals in plans inside of the Exchange. Many commenters requested clarification of the term "consideration."

Response: Prohibiting Navigators from receiving compensation from health insurance issuers for enrolling individuals in health insurance plans is an important way to mitigate potential conflict of interest, and we have amended the final rule in §155.210(d)(4) to establish this prohibition. Permitting Navigators to receive such compensation would introduce a financial conflict of interest which would run counter to the focus of the Navigator program as a consumer-centered assistance resource. We clarify that this prohibition applies to Navigators broadly, including staff of an entity serving as a Navigator or entities that serve as Navigators for one Exchange while simultaneously serving in another capacity for another Exchange. Additionally, we clarify that this prohibition does not preclude Navigators from receiving grants from the Exchange that are funded through the collection of user fees.

We note that the final rule does not inherently prohibit Navigators from receiving grants and other consideration from health insurance issuers for activities unrelated to enrollment into health plans, although we remain concerned that such relationships – financial and otherwise – may present a significant conflict of interest for Navigators. We urge Exchanges to consider the ramifications of such relationships when developing conflict of interest standards for their Navigator programs.

We also clarify that "consideration," as used in §155.210(d)(4) of the final rule, should be interpreted to both mean financial compensation – including monetary or in-kind of any type, including grants – as well as any other type of influence a health insurance issuer could use, including but not limited to things such as gifts and free travel, which may result in steering individuals to particular QHPs offered in the Exchange or plans outside of the Exchange.

Duties of a Navigator

Comment: Many commenters supported the Navigator duties proposed in §155.210(d), and some suggested that the duty to "maintain expertise in eligibility, enrollment, and program specifications" should include knowledge about Exchanges, Medicaid, CHIP, other private and public health insurance programs, appeals, and rules related to cost-sharing. Other commenters recommended other specific minimum duties for Navigators, including providing information about total plan costs, assisting consumers with applying for advance payments of premium tax credit and other cost-sharing reductions, and making consumers aware of the tax implications of their enrollment decisions.

Response: The final rule maintains most of the duties set forth in the proposed rule, except as re-assigned as §155.210(e) and reflecting edited language in §155.210(e)(3). The change in §155.210(e)(3) is a technical correction to ensure consistency with our clarification in §155.205(b)(7). Similarly, a Navigator facilitating a QHP selection for a consumer initiates the enrollment process, which is then conducted by the Exchange. Section 155.400(a)(2) of this final rule describes the subsequent step in the enrollment process, and directs Exchanges to transmit the QHP selection to the appropriate QHP issuer.

We believe that Navigators should make consumers aware of the tax implications of their enrollment decisions, and consider this to be included in §155.210(e)(1) of the final rule. Navigators should also provide information about the costs of coverage and assist consumers with applying for advanced payments of the premium tax credit and cost-sharing reductions, and we clarify that §155.210(e)(2) and §155.210(e)(3) of the final rule are intended to include such activities. We also clarify that such assistance could result in an individual receiving an eligibility determination for other insurance affordability programs. Additionally, we note that

Exchanges can establish additional minimum Navigator duties and encourage Exchanges to determine whether additional Navigator duties may be appropriate.

Comment: A significant number of commenters recommended that Navigators be accessible to all consumers, including those with disabilities, and that all information provided under §155.210(d)(5) of the proposed rule by Navigators be provided orally as well as in writing.

Response: Navigators need to be accessible to individuals with disabilities, and redesignated §155.210(e)(5) of the final rule establishes that Navigators must ensure accessibility and usability for individuals with disabilities, which we believe includes accessibility by individuals with hearing or visual impairments and using enrollment tools, written in plain language, that are easily accessible by consumers. We believe this provision will help ensure that Navigators minimize obstacles to access for all potential enrollees and remain accessible to consumers. Exchanges have the flexibility to develop materials or to assign the responsibility to Navigators.

Comment: Many commenters expressed the need for Navigators to be linguistically and culturally competent, as described in §155.210(d)(5) of the proposed rule, and a significant number recommended training in this area. Commenters had numerous specific recommendations regarding how Navigators would be able to best accomplish this duty, and other commenters wanted additional clarity regarding this standard. Some commenters recommended that Navigator programs select diverse Navigators as a method of reinforcing linguistic and cultural competence. One commenter suggested that having a consumer's family members or friends serve as interpreters should not be permitted to fulfill the obligation to provide culturally and linguistic appropriate services.

Response: Redesignated §155.210(e)(5) establishes that Navigators must provide

information in a way that is culturally and linguistically accessible to ensure that as many consumers as possible can benefit from Navigator programs. The linguistic and cultural accessibility standard applies broadly across the duties of a Navigator, including public education and outreach activities. We encourage Exchanges to undertake cultural and linguistic analysis of the needs of the populations they intend to serve and to develop training programs that ensure Navigators can meet the needs of such populations. We note that we do not believe that this standard can be met by simply having consumers' family members or friends serve as interpreters. As previously stated, future guidance will set forth model standards related to linguistic and cultural competency.

Comment: Regarding the duties of a Navigator outlined in §155.210(d) of the proposed rule, several commenters expressed the importance of data and the use of information technology for Navigator programs, including Navigator collection of data and narratives regarding consumer experiences. Some consumers also stated that Navigators should collaborate with other programs and entities, including other consumer assistance programs and State governments, so that all groups could mutually share information.

Response: The final rule does not establish that Navigators or the Navigator program must collect data or to ensure compatibility with existing information systems. However, Exchanges have the flexibility to use such tools to ensure that Navigators and Exchanges are best serving consumers.

Funding for Navigators

Comment: One commenter recommended that Navigator compensation by an Exchange described in §155.210(e) of the proposed rule be only in the form of block grants, while another commenter recommended that Navigator grants include distribution on a per capita basis for

enrolling individuals in QHPs offered through the Exchange.

Response: We do not outline a specific compensation structure for Navigators, and we maintain the proposed approach to funding in §155.210(f) of the final rule. This approach does not alter section 1311(i)(6) of the Affordable Care Act that establishes that all funds for Navigator grants come from the operational funds of the Exchange. We note, however, that operational funds of the Exchange may be revenue received by the Exchange through user fees or other revenue sources, so long as the Exchange is self-sustaining. We anticipate that there may be public or private grants available to support certain Exchange functions, such as education and outreach; once received for the purposes of funding Exchange operations, these funds would be operational funds.

Comment: We received numerous comments suggesting that we monitor Navigator programs to ensure that they have sufficient funding under proposed §155.210(e) to meet the needs of all potential enrollees, and several commenters recommended that we issue guidance on minimum funding levels needed to operate sustainable Navigator programs.

Response: While States and Exchanges should ensure that Navigator programs have sufficient funds to ensure that all potential enrollees are capable of being assisted and guided in eligibility and decision-making for coverage in the Exchanges, we believe that minimum funding level for Navigator program needs will vary by State and by populations and therefore do not establish a minimum in §155.210(f) of the final rule.

Comment: We received several comments regarding the use of Medicaid or CHIP funds when Navigators perform administrative functions for those programs. The majority of commenters, primarily consumer and patient advocacy groups, were supportive of using Federal Medicaid and CHIP funds for this purpose, while a small minority was opposed to such an

approach. One commenter recommended that Navigators not perform Medicaid or CHIP administrative functions, stating that these activities are the purview of the State Medicaid program.

Response: We continue to support the position that if a State chooses to permit Navigators to perform or assist with Medicaid and CHIP administrative functions, Medicaid or CHIP agencies may claim Federal funding for a share of expenditures incurred for such activities. A more detailed discussion of this position is in the proposed rule (76 FR 41878).

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.210 of the proposed rule, with the following modifications. In new paragraph (b), we provide that an Exchange must develop and publicly disseminate conflict of interest and training standards for all entities that serve as Navigators. In paragraph (c)(1)(v), we apply the privacy and security standards adopted by the Exchange, as established in §155.260, to Navigators. In paragraph (c)(2), we provided that at least one entity serving as a Navigator must be a community and consumer-focused non-profit. We clarified in paragraphs (d)(2) and (d)(3) that subsidiaries of health insurance issuers and associations that include members of or lobby on behalf of the insurance industry are prohibited from serving as Navigators. In paragraph (d)(4) we clarified that Navigators may not receive compensation from a health insurance issuer in connection with the enrollment of individuals or employees in any health plan, including both QHPs and non-QHPs. Finally, in paragraph (e)(3) we clarified that Navigators must assist consumers in selecting a QHP, thereby initiating the enrollment process.

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

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (a)(3) of this section as an interim final provision, and we are seeking comments on it.

In §155.220, we proposed to codify section 1312(e) of the Affordable Care Act that gives States the option to permit agents or brokers to enroll individuals and employers in QHPs. To ensure that individuals and small groups have access to information about agents and brokers should they wish to use one, we proposed to permit an Exchange to display information about agents and brokers on its Web site or in other publicly available materials. Additionally, recognizing that that an Exchange may wish to work with web-based entities and other entities with experience in health plan enrollment, we sought comment on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchange, and the standards that should apply to an entity performing functions in place of, or on behalf of, an Exchange while acknowledging and meeting the statutory limitation that premium tax credits and cost-sharing reductions be limited to enrollment through the Exchange. We also sought comment on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any implications for security or privacy of such an arrangement.

Comment: A number of commenters sought clarification on whether and how the involvement of agents and brokers described in proposed §155.220 may serve as Navigators under §155.210. Many commenters sought further clarification as to the distinction between the role of agents or brokers and the role of Navigators in the Exchange.

Response: In general, the responsibilities of a Navigator differ from the activities that an agent or broker. For example, the duties of a Navigator described under §155.210(e) of the final rule include providing information regarding various health programs, beyond private health insurance plans, and providing information in a manner that is culturally and linguistically

appropriate to the needs of the population being served by the Exchange. Moreover, any individual or entity serving as a Navigator may not be compensated for enrolling individuals in QHPs or health plans outside of the Exchange; as such, an agent or broker serving as a Navigator would not be permitted to receive compensation from a health insurance issuer for enrolling individuals in particular health plans. That said, nothing precludes an Exchange's Navigator program from including agents and brokers, subject to the conditions of §155.210.

Comment: Several commenters expressed support for the proposed §155.220(a) and the level of flexibility it affords State Exchanges to determine the role of agents and brokers and web-based entities in the Exchange marketplace. Several commenters specifically expressed support for the manner in which the accompanying preamble to the proposed rule described the Exchange as accountable for the actions of web-based entities.

Response: We accept the recommendation that Exchanges have the flexibility to determine the role of agents and brokers, including web-based entities, in their marketplaces. We have retained the language in §155.220(a), which codifies the statutory flexibility that States may determine whether agents and brokers may enroll individuals, employers and employees in QHPs and provide assistance to qualified individuals applying for financial assistance.

Comment: HHS received several comments urging us to prohibit agents and brokers, including web-based brokers, from performing eligibility determinations.

Response: The Exchange must perform eligibility determinations, subject to the standards and flexibility outlined in subpart D of this final rule. We note that an individual cannot enroll in a QHP through the Exchange, nor can a QHP issuer enroll a qualified individual in a QHP through the Exchange, unless such individual completes the single streamlined application to determine eligibility as described in §155.405 and is determined eligible. We have clarified in

§156.265(b)(1) that that enrollment by QHP issuer may be considered "enrollment through the Exchange" only after the Exchange notifies the QHP issuer that the individual has received an eligibility determination, the individual is qualified to enroll in a QHP through the Exchange, and the Exchange transmits enrollment information to the QHP issuer consistent with §155.400(a). In §155.220(c)(1), we also specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual completes the application and eligibility verification process through the Exchange Web site. We acknowledge and clarify that nothing in this final rule prohibits a QHP issuer from selling QHP coverage directly or through an agent or broker, so long as the standards of §156.255(b) are met; however, such sales and enrollment are not "enrollment through the Exchange" and such enrollees are not eligible for the benefits that are tied to enrollment through the Exchange.

Comment: With respect to proposed §155.220(a), several commenters sought clarification of the role agents and brokers in enrolling individuals in QHPs. Several commenters urged us to strengthen the role of agents and brokers in the Exchange by further clarifying their ability to participate in the Exchange marketplace. With respect to the preamble discussion of web-based entities, several commenters urged HHS to permit web-based entities in particular to enroll individuals eligible for advance payments of the premium tax credit and cost-sharing reductions in QHPs so that such individuals may have access to the same avenues for QHP enrollment as those individuals who do not receive financial assistance.

Response: We accept the recommendation that we provide Exchanges with discretion to leverage the market presence of agents and brokers, including web-based entities that are licensed by the State (web-brokers), to draw consumers to the Exchange and to QHPs. We have

amended §155.220 to include minimum standards for the process by which an agent or broker may help enroll an individual in a QHP in a manner that constitutes enrollment through the Exchange. This is intended to include traditional agents and brokers, as well as web-brokers. This process must include the completion by the individual of a single streamlined application to determine eligibility through the Exchange's Web site, as described in §155.405; the transmission of enrollment information by the Exchange to the QHP issuer to allow the issuer to effectuate enrollment of qualified individuals in the QHP; and any standards set forth in an agreement between the agent or broker and the Exchange. We note that there may be various means a State may choose to integrate agents, brokers and web-brokers consistent with the standards described in this section for enrollment through the Exchange. Agents and brokers may assist individuals enrolling directly through the Exchange Web site and may serve as Navigators consistent with standards described in §155.210. We also afford Exchanges discretion to allow agents and brokers to use their own Web sites to assist individuals in completing the QHP selection process, as long as such a Web site conforms to the standards identified in §155.220(c)(3). While Exchanges that pursue this option would be able to leverage the market presence of web-brokers in drawing consumers to the Exchange and QHPs, we note that the Exchanges will also have to share data and coordinate closely with such entities.

Comment: With respect to proposed §155.220(a), many commenters urged us to set standards around the use of agents and brokers in order to ensure certain consumer protections. These suggestions included having Exchanges to monitor and oversee all agents and brokers enrolling individuals and small groups in QHPs; establishing provisions to mitigate agents' and brokers' incentives to steer consumers to enroll in certain QHPs or to non-QHPs; setting uniform commissions for agents and brokers or establishing that issuers must compensate agents and

brokers the same amount for Exchange and non-Exchange plans; prohibiting commissions for agents and brokers in the Exchange altogether; establishing certain disclosures by agents and brokers, including disclosure of their commission and whether or not the agent or broker has been the subject of any sanctions; applying privacy and confidentiality standards to agents and brokers; prohibiting Exchanges from directing individuals or small groups to enroll only through an agent or broker; prohibiting advertising by agents or brokers; or prohibiting agents and brokers from the Exchange altogether.

A number of commenters also expressed concern regarding the role of third-party web-based entities enrolling individuals in QHPs. Several commenters emphasized that such external entities should be held to the same standards as the Exchange; should not be permitted to perform eligibility determinations; or should be held to certain consumer protection standards to prevent steering.

Response: We recognize the importance of consumer protections with respect to agents and broker interactions. We also recognize the States' role in licensing and overseeing agents and brokers and have allowed States to determine which standards would apply to agents and brokers acting in the Exchange, if the State chooses to permit agents and brokers to enroll individuals and small groups in QHPs through the Exchange. In order to address commenters' concerns while maintaining the State's primary role in overseeing agents and brokers, we have added paragraph (d) to ensure that agents and brokers must comply with an agreement with the Exchange under which the agent or broker would comply with the Exchange's privacy and security standards that are adopted consistent with §155.260 and §155.270. We have also added paragraph (e) to ensure that agents and brokers comply with applicable State law.

We also recognize that the role of web-brokers may evolve upon implementation of

Exchanges, and that Exchanges may seek to involve web-brokers in the enrollment process using a variety of technologies. We have set forth standards in this rule to ensure that consumers enjoy a seamless experience with appropriate consumer protections if an Exchange chooses to allow web-brokers to participate in Exchange enrollment activities. In order to address commenters' particular concerns around the role of web-based entities, we note that eligibility determinations must be conducted by the Exchange and enrollment information must be transmitted to the QHP issuer by the Exchange. We have added paragraph (c)(3) to §155.220 to ensure that Web sites used by agents or brokers to enroll individuals in a manner that constitutes enrollment through the Exchange provide consumers with access to the same information as they would if they used the Exchange Web site instead. Based on several commenters' suggestion that we address agents' and brokers' ability to steer or incentivize consumers to enroll in certain QHPs, and commenters' general concern about the fact that the existence of such Web sites may confuse consumers, we have inserted standards under paragraph (c)(3) of this section to prevent such web-brokers from providing financial incentives and to establish that such Web sites must allow consumers to withdraw from the web-broker's process and use the Exchange Web site instead at any time. Furthermore, the web-brokers would also be subject to the standards inserted under paragraph (d) and (e) regarding compliance with an agreement with the Exchange and State law, respectively.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.220 of the proposed rule, with several modifications. In the new paragraph (a)(2), we clarify that agents and brokers may enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange. In new paragraph (a)(3), we clarify that agents and brokers may assist individuals in applying for

advance payments of the premium tax credit and cost-sharing reductions for QHPs. As noted elsewhere in this rule, paragraph (a)(3) is being published as interim. We outline the parameters of what is considered enrollment through the Exchange in the newly added paragraph (c), including that an agent or broker must ensure that an individual completes the eligibility verification process through the Exchange and that the Exchange transmits enrollment information to the QHP issuer consistent with §155.400(a). In paragraphs (d) and (e), respectively, we establish that agents or brokers must comply with the terms of an agreement with the Exchange as well as applicable State laws. New paragraph (c)(3) establishes standards that would apply for an agent or broker's Internet Web site were to be used to assist individuals in selecting a QHP within the framework of enrollment through the Exchange.

f. General standards for Exchange notices (§155.230)

In §155.230, we proposed standards for any notice sent by an Exchange in accordance with part 155. We additionally proposed that all applications, forms, and notices be provided in plain language, and be written in a manner that provides meaningful access to individuals with limited English proficiency and ensures effective communication for people with disabilities. We sought comment on whether we should codify specific examples of meaningful access in the final rule. We also proposed that the Exchange annually re-evaluate the appropriateness and usability of all applications, forms, and notices and consult with HHS when changes are made.

Comment: Several commenters expressed support for proposed §155.230(a) that provides that any notice sent by the Exchange in accordance with part 155 must be in writing and include the information described in paragraphs (a)(1) through (a)(3). Many commenters further specified that the Exchange should send a second notice, or multiple notices, when the action taken in a notice (of eligibility determination) will result in a termination of coverage or another

adverse action. Some commenters provided other specific recommendations about the content, timing, and formatting of notices, particularly for the purpose of clarity and applicability of relevant information on the part of the consumer. For example, some commenters specified that notices should include the relevant and appropriate range of customer service resource contact information based on the specific individual's location or circumstances. Some commenters suggested that HHS issue model notices or best practices for crafting notices for States, and commenters suggested that HHS develop templates or minimum standards of forms and notices.

Response: We believe that notices should be in writing, electronically whenever possible, and we are taking specific content, timing, and format-related recommendations we received from commenters into consideration as we move forward with development of model Exchange-issued notices. While §155.230(a)(1) through (a)(3) outline some specific content standards for notices, we plan to issue model notices. In addition to the content specific standards described under §155.230(a), we expect that notices will also include the date on which the notice is sent. In §155.230(a)(3) we add that a notice must include the reason for the intended action.

Comment: Several commenters recommended that applicants and enrollees should be able to specify their preferred method of communication for notices, including the option to receive duplicative notices, and that electronic notices should fulfill the Exchanges' obligation to provide notices in writing in accordance with §155.230(a). A few commenters requested clarification concerning whether Medicaid/CHIP will provide future guidance on the use of electronic communications.

Response: In the final rule, we do not make changes to address the use of electronic notices. In coordination with Medicaid and CHIP, we will address standards related to electronic notices and coordination of notices between the Exchange, Medicaid, and CHIP in future

rulemaking. We note that our goal is to allow for electronic notices wherever practical. Future rulemaking in coordination with Medicaid and CHIP will also increase our ability to align standards across programs.

Comment: One commenter recommended that HHS consider whether it is necessary to set a specific timeline or clarify how quickly applications and notices must be processed by the Exchange. Another commenter suggested that the language for §155.230 be expanded to refer to "applications, forms, notices and any other documents sent by an Exchange."

Response: We have not included general timeliness standards in §155.230 of this final rule, as we did not propose them. However, subpart D contains timeliness standards related to eligibility determinations as interim final rules. In addition, as we develop model notices and future guidance, we will consider both notice timeliness standards and the applicability of §155.230 to other documents issued by the Exchange.

Comment: A few commenters recommended that HHS remove "if applicable" from proposed §155.230(a)(2) that reads: "An explanation of appeal rights, if applicable."

Response: Section 155.230 applies to all notices in accordance with part 155. However, in some cases, a notice of appeal rights is not relevant. For example, the notice of the annual open enrollment period in accordance with §155.410(d) does not provide information specific to an individual and is not appealable. In contrast, the Exchange must include the notice of the right to appeal and instructions regarding how to file an appeal in any determination notice issued to the applicant in accordance with §155.310(g), §155.330(e), or §155.335(h) of subpart D. We intend to address appeal rights and procedures in future rulemaking.

Comment: A majority of commenters supported the approach described in §155.230(b) of the proposed rule, while others suggested that HHS add more detail to accessibility standards.

Many commenters recommended that we provide specific standards and thresholds for translation of written information, and be understandable to limited English proficient populations. One common suggested threshold was to provide written translations where 5 percent or 500 limited English proficient individuals reside in the State or Exchange service area, whichever is less. Many commenters also recommended we add specific standards with respect to oral interpretation, including at no cost to the individual, and informing individuals how to access these services through use of "taglines" in at least 15 languages. A few commenters asked for flexibility for States in developing language services standards as States' populations and needs differ, and one commenter expressed concern that a specific, uniform standard could pose an unreasonable burden.

Response: In response to these comments, we have modified our proposed regulation at §155.230(b) to cross-reference the accessibility, readability, and translation and oral interpretation standards outlined in §155.205(c). We plan to put forth guidelines relating to these standards in upcoming guidance.

Comment: Many commenters noted the importance of health literacy and the need to provide information that is readable and understandable. A few commenters suggested that the reading level of informational materials should be not greater than the 6th grade reading level.

Response: We recognize the importance of health literacy and significance of providing readable and understandable information. We will take these comments into consideration as we develop guidance that sets more specific standards and thresholds for readability, and as we develop joint guidance with the Department of Labor related to "plain language." However, we have decided not to add specific reading level standards in the final rule.

Comment: While some commenters expressed support for the proposed §155.230(c) that

the Exchange review notices on an annual basis, other commenters were concerned about the burdensome and costly nature of an annual review. Some commenters instead suggested that such a review occur every three years or "periodically." Several commenters recommended that Exchanges have flexibility in how they implement provision of notices and provided specific examples (that is, flexibility in content), while one commenter advised that Federal standards should provide a floor for notices but not diminish stronger standards that the State may have for notices. Commenters who supported an annual review also suggested that Exchanges seek consumer and stakeholder input as notices are developed and changes to notices are made. Some commenters also expressed support for or sought clarification related to how a State must consult with HHS when changes are made to notices, particularly regarding the scope of such a consultation. A few commenters suggested that notices should be reviewed annually as a part of the recertification process.

Response: In §155.230(c) of the final rule, we revise the language from the proposed rule to provide that the Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices without specifying the interval at which such review must occur. Due to commenters' concerns about the feasibility and burden of an annual review and the request for flexibility regarding notices implementation, we removed the standard that this review must occur on an annual basis. We anticipate that the model notices developed by HHS will help to ensure that Exchanges include the appropriate content for their notices and reduce administrative burden and cost to Exchanges. We will consider the feasibility of reviewing notices, and notably any proposed changes made to notices, and will consider stakeholder input, particularly Exchanges and State Medicaid programs, as the model notices are developed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.230 of the proposed rule, with several modifications: we clarify in paragraph (b) that applications, forms and notices must comply with the readability and accessibility standards established in §155.205(c) for the Exchange Internet Web site. In paragraph (c), we removed the proposed provision that the Exchange must re-evaluate applications, forms, and notices on an annual basis and also removed that the Exchange must consult with HHS when changes are made. In §155.230(a)(3), we add that a notice must include the reason for the intended action.

g. Payment of premiums (§155.240)

In §155.240, we proposed that Exchanges must always allow an individual, at his or her option, to pay the premium directly to the QHP issuer. In addition, we proposed that an Exchange may permit Indian tribes, tribal organizations and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals, subject to the terms and conditions determined by the Exchange. We solicited comment on how such an approach might work in an Exchange. We also invited comment on how to distinguish between individuals eligible for assistance under the Affordable Care Act and those who are not in light of the different definitions of "Indian" that apply for other Exchange provisions. With respect to the operation of a SHOP, we proposed that an Exchange must accept payment of an aggregate premium by a qualified employer.

Finally, we proposed that an Exchange may facilitate electronic collection and payment of premiums. We sought comment concerning Exchange flexibility in establishing the premium payment process and what Federal regulatory standards would be appropriate to ensure fiduciary accountability when an Exchange collects premiums.

Comment: One commenter suggested that QHP issuers report to an Exchange if an individual pays the issuer directly under the option described in §155.240(a).

Response: We believe that this information will be transmitted from a QHP issuer and an Exchange through the process of effectuating enrollment through the Exchange and through the process to initiate advance payments of the premium tax credit and cost-sharing reductions. We outline reporting standards related to enrollment and notification if an individual stops payment in §155.400, §155.430, and §156.270.

Comment: One commenter suggested that issuers should be responsible for collecting premiums directly from individuals, as described in proposed §155.240(a), but that the Exchange should be permitted to garnish wages or undertake other legal means to collect unpaid premiums owed to QHP issuers.

Response: We clarify that nothing in the final rule imposes a responsibility on Exchanges to pursue unpaid premiums on behalf of a QHP issuer. We do not believe the Exchange should take on debt collection responsibilities for issuers.

Comment: With regard to proposed §155.240(a), one commenter suggested that a possible interpretation of section 1312(b) of the Affordable Care Act is that payment facilitation by an Exchange could be considered direct payment by the individual to the QHP issuer.

Response: We interpret section 1312(b) of the Affordable Care Act to mean that individuals always have the option to pay a QHP issuer directly, and therefore, we maintain this policy as proposed.

Comment: In response to §155.240(b) of the proposed rule, several commenters recommended that Exchanges must allow Indian tribes, tribal organizations, and urban Indian organizations to pay the unsubsidized portion of QHP premiums on behalf of enrollees. Some

commenters noted that Indian tribes have a right to use Federal funds to pay insurance premiums on behalf of their members and a sovereign right to use their own funds for that purpose. Other commenters recommended that the Exchange accepts aggregated payments from employers so it should also accept aggregated payments from tribes, tribal organizations, and urban Indian organizations. A few commenters recommended that HHS eliminate the qualifier, "subject to the terms and conditions determined by the Exchange," in the final rule.

Response: We did not accept the recommendation that Exchanges must permit Indian tribes, tribal organizations and urban Indian organizations to pay premiums on behalf of enrollees. Premium aggregation is a unique function of the SHOP Exchange, and is not identified as a function of the individual market Exchange. However, we recognize that some Exchanges may wish to work with tribal governments to facilitate payment on behalf of enrollees, including aggregated payment. We encourage Exchanges to include this option as part of its consultation with tribal governments. This rule does not prohibit a QHP issuer from accepting third-party payments of premiums from tribal governments, tribal organizations, or urban Indian organizations for enrollees through the Exchange.

Comment: Many commenters supported the option for an Exchange to act as a premium facilitator or aggregator for the individual market, as permitted under §155.240(d). Several commenters suggested strengthening the standard by establishing that Exchanges must have the capacity to facilitate payments in the individual market citing benefits such as ease for consumer, consistent source of payments for QHP issuers, program integrity, and provision of real-time enrollment and payment data for Exchange monitoring. Others suggested a standard that Exchanges set a default payment, and suggested that Exchanges provide multiple avenues for payment including premium facilitation, direct to issuer, in person, online, by phone, by mail,

and through cash, debit, credit, check, or automatic electronic transfers. One commenter suggested that the Exchange Blueprint address how complexity added by multiple payment options would be mitigated and another commenter recommended that an individual select the payment methodology at the time of enrollment for that benefit year.

Response: Premium aggregation has potential benefits for individuals, but we also do not think that there are sufficient disadvantages in having individuals pay QHP issuers directly to warrant establishing premium aggregation as a minimum standard. We believe that the final rule balances the potential benefits of premium collection in the individual market with State flexibility. We encourage all Exchanges to provide consumers with multiple payment options that facilitate enrollment and avoid creating payment processes that create barriers. We note that Exchanges have the flexibility to create a default payment mechanism through the Exchange, and to direct individuals to select a payment option for a year at the time of enrollment.

Comment: Several commenters oppose proposed §155.240(d) that allows for an Exchange to facilitate the collection and payment of premiums for the individual market. Commenters were concerned with several areas including cost, the timeliness of payments getting from consumers to the issue, and the additional complexity in the case of errors.

Response: We believe that premium aggregation may add value to an Exchange for consumers through ease of payment and to QHP issuers through having a single source of payment. Without premium aggregation in the small group market, a single entity would have to pay a variety of QHP issuers to administer its group health plan. However, the burden for paying premiums directly to QHP issuers is much less for individuals and families who are likely to be enrolled in a single QHP. Thus, premium aggregation is a minimum function of a SHOP, while it is optional for the individual market. We note that because an Exchange will need to establish

premium aggregation functionality for a SHOP, it may be able to offer this option to individuals without additional up-front costs.

Comment: One commenter suggested that proposed §155.240(d) ban paperwork for financial transactions and, instead, call for the use of electronic methods exclusively to lower administrative costs and allow quick feedback between Exchanges, qualified individuals, qualified employers, and QHP issuers.

Response: We believe that electronic payment methods have many benefits, and encourage Exchanges to use them where possible, but also acknowledge that electronic payment methods may not always be optimal for all consumers and may not be possible for all Exchanges. Therefore, it is not a minimum standard in this final rule.

Comment: Most commenters supported the proposed §155.240(e) to adopt electronic means of collecting premium payments by individuals and employers, and the accompanying application of the privacy and standards outlined in §155.260 and §155.270. One commenter recommended deleting the cross reference to §155.260, because this section related to privacy and security, not electronic transaction standards.

Response: We have maintained the cross-reference to §155.260 in this final rule. Section 155.240(e) is meant to establish compliance with both electronic transactions standards in §155.270 and privacy and security provisions of §155.260. Because personally identifiable information may be exchanged in the process of premium payment, we believe the protections for collection, use and disclosure of information contained in standard transactions for premium payments are as vital as the format of these transactions.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.240 with the exception of the removal

of proposed paragraph (c), as we believe that payment of premiums by qualified employers is sufficiently addressed in §155.705. The other paragraphs have been re-numbered accordingly in the final rule.

h. Privacy and security of information (§155.260)

In proposed §155.260, we addressed the privacy and security standards Exchanges must establish and follow. Specifically, we proposed that the Exchange apply appropriate security and privacy protections when collecting, using, disclosing or disposing of any personally identifiable information. In addition, we proposed that an Exchange apply these standards on contractors or sub-contractors through contracts or agreements with the Exchange.

We defined personally identifiable information (PII) and proposed prohibiting the collection, use, or disclosure of PII by the Exchanges unless: (1) required or permitted by §155.260 of this subpart or other applicable law, and (2) the collection, use, or disclosure is made in accordance with subpart E of this part, §155.200(c) of this subpart and section 1942 of the Act. We invited comment as to whether and how we should restrict the method of disposal in this section.

We also proposed that the security standards of the Exchange be consistent with HIPAA security rules described at 45 CFR 164.306, 164.308, 164.310, 164.312, and 164.314. We solicited comment on the aptness of adopting the HIPAA Privacy Rule's standards for Exchanges. Alternatively, we proposed to provide States with the flexibility to create a more appropriate and tailored standard, given the varied types of information to which the Exchange would have access. We noted that we were considering directing each Exchange to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs), and sought comment on the appropriateness of FIPPs in this context and the best means to integrate FIPPs into the

privacy policies and operating procedures of individual Exchanges. We listed examples of FIPPs-based principles derived from the Nationwide Privacy and Security Framework for the Electronic Exchange of Individually Identifiable Health Information, which is a model developed by the Office of the National Coordinator for Health IT. These are not purely FIPPs principles, but examples of how they may be used to develop robust privacy and security standards.

We also proposed that security policies and procedures must be in writing and available to the Secretary of HHS, and must identify any applicable laws that the Exchange will need to follow. In addition, we proposed that any data matching arrangements between the Exchange and agencies that administer Medicaid and CHIP for the exchange of eligibility information be consistent with all applicable laws. We also proposed that return information is kept confidential under section 6103 of the Code.

Finally, we proposed that any person that knowingly and willfully uses or discloses personally identifiable information inappropriately would be subject to a civil money penalty of not more than $25,000 per disclosure and any other applicable penalties that may be prescribed by law.

Comment: Many commenters recommended that HHS set a national minimum standard for use and disclosure of personally identifiable information (PII) under proposed §155.260(b) rather than allow each Exchange flexibility to develop and implement standards customized to its operations. One commenter stated that HHS should harmonize State and Federal laws for the development and operation of information technology systems across all States. Commenters suggested adopting different existing privacy and/or security standards alone or in various combinations, including the Fair Information Practice Principles (FIPPs) model adopted by the Office of the National Coordinator for Health Information Technology, HIPAA Privacy, HIPAA

Security, the Privacy Act, Medicaid standards at section 1902(a)(7) of the Act, the confidentiality and disclosure provisions of the Department of Homeland Security's Systematic Alien Verification for Entitlements (SAVE) program (42 U.S.C. 1320b-7), the HITECH Act, and the Gramm-Leach-Bliley Act (GLBA).

Response: We recognize that there should be robust minimum privacy and security standards to ensure the confidentiality and integrity of PII created, collected, used, or disclosed by an Exchange. We also accept the comment that each Exchange will need to consider any State and Federal laws governing individuals' privacy and security rights for the geographic area(s) in which it operates in order to ensure PII is protected against any reasonably anticipated uses or disclosures that are not permitted or required by law. We acknowledge the current variance among States' laws governing privacy and security, but believe that eliminating this variance would, in many cases, apply Federal standards to existing State privacy and security frameworks. This would be prohibitively expensive for many States, and could be detrimental to the goal of maintaining the confidentiality of PII. In addition, multiple security frameworks increase the complexity of the technological environment—if a State must follow two different frameworks, there is an increased risk of applying the wrong security controls to the Exchange. Finally, but equally important, we recognize the need for flexibility in the implementation of these standards in order to minimize implementation costs. The imposition of uniform standards would increase costs related to re-training staff, engaging contractors, investing in additional physical and technological infrastructure, and other tasks related to implementation of the new standards. We believe it would increase the complexity of State operations, with associated risks and costs, without providing meaningful improvements to the protection of PII.

In the final rule, we do not establish a single, baseline standard. We direct an Exchange to

put in place safeguards that ensure a set of critical security outcomes, and we present a framework within which an Exchange must create its privacy and security policies and protocols. We specify that an Exchange establish and implement privacy and security standards that are consistent with the FIPPs-based principles identified in the "Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information," the model adopted by the Office of the National Coordinator for Health Information Technology[3]. In addition to these FIPPs-based principles, §155.260(a)(4) of this final rule directs Exchanges to establish and implement operational, technical, administrative, and physical safeguards that will ensure a set of defined privacy and security outcomes. We believe the standards in this final rule will minimize burden by allowing HHS and the States to leverage existing security infrastructure and allow Exchanges to tailor their privacy and security approaches to the types of information Exchanges will create, collect, use, and disclose, while providing a baseline set of standards and critical outcomes upon which all States must base their privacy and security policies and protocols.

We plan to release guidance to assist States in developing and implementing privacy and security policies and protocols that fulfill the standards of this section. In addition, HHS will assist States in the development of policies and protocols as part of the reviews and technical assistance provided to grantees under the section 1311(a) of the Affordable Care Act.

Comment: A large group of commenters requested that HHS codify sections 1411(g), 1413(c)(2), and 1414(a) of the Affordable Care Act. Several commenters recommended amending the language in proposed §155.260(b)(1)(i) to explicitly establish that, based on section 1411(g) of the Affordable Care Act, information may not be created, collected, used, or

[3] Nationwide Privacy and Security Framework for Electronic Exchange of Individually Identifiable Health Information: http://healthit.hhs.gov/portal/server.pt/community/healthit_hhs_gov__privacy___security_framework/1173.

disclosed unless "strictly necessary." One commenter recommended that we remove the reference to "other applicable law" and replace it with specific references to sections 1411(g) and 1557 of the Affordable Care Act, sections 1942 and 1137 of the Act, and the Privacy Act of 1974.

Response: We believe that privacy and security of PII is of utmost importance. Accordingly, in the final rule, we have made major changes to the Exchange privacy and security standards, both to give more specific guidance to States as they implement the Exchange program, and to ensure confidentiality for individuals who may interact with Exchanges. As stated in the preamble to the proposed rule, we looked to sections 1411(g), 1413(c)(2), and 1414(a) of the Affordable Care Act as the basis for many of the provisions in the proposed regulatory text. First, we removed proposed paragraph (a), which defined personally identifiable information in the context of the Exchange program. This is a broadly used term across Federal agencies, and has been defined in the Office of Management and Budget Memorandum M-07-16. In order to reduce duplicative guidance or potentially conflicting regulatory language, we have removed this portion of the proposed rule, and point to the aforementioned memorandum as the source of this definition.

Paragraph (a)(1) of the final rule specifically addresses PII that is created or collected for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code. This paragraph limits the purposes for which the Exchange can use this information to those outlined in §155.200 of this subpart.

Paragraph (a)(2) is broader in scope than paragraph (a)(1), and includes all information collected for the purposes of carrying out Exchange minimum functions described in §155.200.

This paragraph prohibits the creation, collection, use or disclosure of PII unless the manner in which the Exchange does so is consistent with the privacy and security standards outlined in §155.260(a).

Paragraphs (a)(3) through (a)(4) outline the privacy and security principles and critical outcomes, and set expectations for development of privacy and security protocols by Exchanges, and new paragraph (a)(5) specifies that the Exchange must monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of those controls. We also inserted the provision from section 1413(c)(1) of the Affordable Care Act that an Exchange must develop and utilize secure electronic interfaces when sharing PII in §155.260(a)(6).

We are not amending the final rule to codify section 1414(a) of the Affordable Care Act, because it falls under the jurisdiction of the Department of the Treasury. We are not codifying section 1557 of the Affordable Care Act because it is outside the scope of this rule. We are not codifying section 1137 of the Act, which includes standards for States' income and eligibility verification systems, in this final rule because it does not impose any additional privacy or security standards. In addition, section 1413(c)(3) of the Affordable Care Act simply directs that an Exchange can only determine eligibility on the basis of reliable, third party data, which is outside the scope of this section. We note that while the final rule does not propose to codify these listed provisions, Exchanges will need to comply with applicable laws that are outside the scope of this rulemaking.

Comment: A number of commenters requested clarification regarding HIPAA and Exchanges. One commenter requested that HHS declare that HIPAA applies to all Exchanges, but many commenters discouraged the use of this standard. A few commenters specifically

requested that HHS not use HIPAA as the privacy standard. One commenter stated that applying HIPAA Privacy to non-HIPAA entities might permit broader collection, use, and disclosure of data than was intended by Congress in statutory limits set forth in section 1411(g) of the Affordable Care Act. Another commenter added that HIPAA lacks controls associated with new technologies.

Response: We believe HIPAA is not broad enough to adequately protect the various types of PII that will be created, collected, used, and disclosed by Exchanges and individuals or entities who have access to information created, collected, used, and disclosed by Exchanges. We recognize that there will be aspects of Exchanges, as health insurance marketplaces, that will not be reached by the HIPAA regulations governing health plans, certain providers, and clearinghouses (that is, "HIPAA covered entities"). In clarifying these points, however, it is important to recognize that the privacy and security standards that are adopted in this rule do not obviate the need for HIPAA covered entities to meet the HIPAA Privacy and Security Rules' standards. The Exchange sections of the Affordable Care Act did not alter the applicability of HIPAA to HIPAA covered entities.

To avoid any further confusion on this point, we believe that it is advisable to remove any specific regulatory references to HIPAA in proposed §155.260(b), which we have redesignated as §155.260(a) of this final rule. We replaced such references with the standards outlined in the first response in this section. We believe that the privacy and security standards in the final rule are analogs of the HIPAA policies in the proposed rule, with similar standards and restrictions. As stated in the preamble discussion to §155.260 in the proposed rule, each State will need to conduct an analysis of its operations and functions to determine its HIPAA status based on the definitions in 45 CFR 160.103, and, when applicable, meet any and all obligations under those

regulations in addition to any Exchange standards. For instance, a State may need to consider whether the Exchange performs eligibility assessments for Medicaid and CHIP, based on MAGI, or conducts eligibility determinations for Medicaid and CHIP as described in §155.302(b).

We have inserted language in § 155.200 of the final rule that will clarify the relationship between an Exchange and a QHP—as noted therein, nothing in this final rule should be construed to create a relationship between an Exchange and a QHP whereby an Exchange performs functions on behalf of a QHP. Further, we intend to release guidance that will assist States in determining the applicability of HIPAA and other Federal laws to Exchanges.

Comment: Several commenters suggested that HHS encourage States to apply privacy and security standards that are stricter than the minimum standard set forth by HHS regulations. Others asked that HHS make clear in the final rule that, even if an Exchange is covered by a single standard, it will continue to be subject to additional rules set by HHS and the States. Commenters asserted that State law regarding privacy and security should remain applicable. One commenter stated that HHS should provide States with the flexibility to enact more stringent standards based on those States' determination of the most appropriate standard.

Response: We accept commenters' suggestion that States retain the discretion to apply more stringent standards than the minimum privacy and security standards imposed by this section. Nothing in this final rule prevents or otherwise impairs the applicability of more stringent State law. Equally, we note that nothing in this final rule obviates the need to meet any other applicable Federal privacy and security laws.

Comment: One commenter asserted that HHS does not have the authority to require Exchanges to provide access to its data protection policies and procedures to HHS. The commenter requested that HHS provide an explanation of why it wants or needs access to an

Exchange's data protection policies and procedures and what it plans to do with that information. The commenter also stated that HHS has no enforcement authority over State-based Exchanges and therefore may not take "action" against an Exchange with data protection policies and procedures the Secretary deems "inadequate." In contrast, several commenters supported the provision in the proposed rule that Exchanges develop policies and procedures regarding the use, disclosure, and disposal of PII. Many commenters asked that these policies and procedures be available to the public, and that HHS ensure that Exchanges engage stakeholders, including consumers, in the development of these policies and allow for public comment prior to submission to the Secretary. A few commenters asserted that these policies and procedures be part of the written Exchange Blueprint, in accordance with §155.105 of the proposed rule, or another similar document that is available to the public.

Response: The Secretary has broad authority under section 1321(a) of the Affordable Care Act to issue appropriate regulations and standards with respect to the operation of Exchanges. Due to the private nature of the information provided to Exchanges, we believe that a process that allows the Secretary to ensure continued compliance with the privacy and security standards of §155.260 is not only appropriate, but necessary. According to section 1321(c) of the Affordable Care Act, the Secretary has the authority to determine whether a State Exchange meets the requisite standards to operate. If the Exchange fails to meet these standards, the Secretary may establish and operate a Federally-facilitated Exchange in that State.

In addition, the Affordable Care Act also gives HHS an audit enforcement mechanism under section 1313. We believe the Secretary has broad authority to ensure the submission of these policies in accordance with 1313(a)(3) of the Affordable Care Act. This information is necessary to ensure the integrity of the Exchange and its related activities and to protect

confidential consumer information. However, Exchanges do not have to release these policies and protocols to the public because this disclosure might reveal information that could damage the State's ability to maintain the integrity and security of its systems. Finally, while we have not included the privacy and security policies and protocols in the Exchange Blueprint, we believe we have the authority to do so if deemed appropriate by the Secretary.

Comment: Many commenters recommended that the privacy and security standards in proposed §155.260 apply to application assisters, Navigators, contractors, other individuals who have access to PII gathered from individuals or available through an Exchange. One commenter asserted that the final rule should clearly affirm the obligation of these parties to abide by all Federal confidentiality and privacy laws.

Response: Individuals who have agreements with an Exchange that can collect, use, or disclose PII as part of their Exchange-related activities should comply with the final rule's privacy and security standards. However, we do not believe the Affordable Care Act grants the Secretary the authority to regulate all individuals and entities directly. Such authority is limited to the Exchange, who can impose these standards on individuals and entities that enter into agreements with the Exchange, such as contractors, agents, and brokers, and HHS grantees, such as Navigators. We have added §155.260(b) of the final rule, which ensures that Exchanges impose privacy and security standards that are the same or more stringent than the privacy and security standards in §155.260(a) as a condition of the agreement with other individuals or entities that will receive information through the Exchange.

Comment: Several commenters asked that HHS provide notice to individuals who share PII with an Exchange. Commenters also asked that HHS direct Exchanges to notify individuals of their privacy rights and note why the information is being collected prior to asking individuals

to submit PII. One commenter said HHS should not share protected health information (PHI) without written consent before each disclosure.

Response: We believe the FIPPs-based principles in the final rule ensure that an Exchange will make individuals aware of the purpose of any information collection as well as the privacy policies that affect individuals and their PII. We have added language to new section §155.260(a)(3)(iv) that an Exchange must develop privacy and security policies and protocols that are consistent with the FIPPs-based principle of "Individual Choice," which states that individuals should be provided a reasonable opportunity and capability to make informed decisions about the collection, use, and disclosure of their personally identifiable information. In addition, in new §155.260(a)(3)(iii), we establish that an Exchange's policies and protocols must be consistent with the principle of "Openness and Transparency," which states that there should be openness and transparency about policies, procedures, and technologies that directly affect individuals and/or their personally identifiable health information. In addition, if a State determines that its Exchange is a HIPAA covered entity or business associate, as defined in 45 CFR 160.103, that Exchange must adhere to any applicable HIPAA privacy and security standards, including those regarding the protection of protected health information (PHI). The final rule addresses only personally identifiable information, as defined in §155.260(a) and does not modify HIPAA.

Comment: A handful of commenters stated that Exchanges should obtain specific authorization from individuals prior to using any PII for marketing purposes. Some commenters requested that HHS prohibit Exchanges from sharing any information for marketing or fundraising purposes altogether. One commenter stated that HHS should specifically prohibit Exchanges from selling data, or allowing access to PII collected for Exchange purposes for data

mining. Another commenter stated that HHS should specifically prohibit any secondary uses of PII that are not specifically authorized.

Response: Section 155.260(a) does not permit the use or disclosure of PII for marketing or fundraising purposes. The final rule clarifies that PII collected for those purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, or determining eligibility for exemptions from the individual responsibility provisions in section 5000A of the Code, can only be used to the extent such information is necessary to carry out minimum functions in §155.200 of this subpart.

Comment: Two commenters stated that HHS should be able to collect demographic information on a voluntary basis through the Exchange. Commenters believe that collection of demographic information would help to provide essential health information on vulnerable or underserved populations, facilitate tailored outreach and aid in enrollment activities, and provide input in the development of prevention and health care programming that address disparities.

Response: Section 1411(g) of the Affordable Care Act does not prohibit the collection of demographic data. We respond to this issue in greater depth in the preamble to §155.405, which addresses the single, streamlined application.

Comment: Several commenters requested that HHS specify in the final rule that Social Security numbers should be collected for limited purposes. These commenters stated that Social Security numbers should be shared only for the purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions. Two commenters stated that Social Security numbers should be shared only for the purpose of identification of an individual.

Response: Sections 1411(b) and (c) of the Affordable Care Act give the Secretary the authority to ensure that applicants for enrollment in a QHP offered through an Exchange provide

a Social Security number so that an Exchange can perform the requisite eligibility determination. While we believe that an individual's Social Security number should be collected and used for limited purposes, the use of an individual's Social Security number is essential to complete functions beyond identification—for example, the verifications described in sections 1411(c), (d), and (e) of the Affordable Care Act.

Comment: One commenter stated that HHS should establish criteria for the collection and retention of information when a consumer is a survivor or victim of domestic violence based on policies of child support collection programs.

Response: We do not believe that the final rule should contain the specific data collection for vulnerable populations for purposes other than those defined in the statute.

Comment: Two commenters asked that HHS ensure that Exchanges promptly notify potentially affected enrollees in the event of a data breach or unauthorized access to PII. One commenter suggested that HHS ensure that an Exchange conducts an investigation and hold the breaching party accountable, both legally and financially, for notification and investigation following the breach or unauthorized access.

Response: We do not plan to include the specific notification procedures in the final rule. Consistent with this approach, we do not include specific policies for investigation of data breaches in this final rule. We do, however, plan to release guidance that addresses breach procedures.

Comment: One commenter requested that the final rule include privacy and security standards for storage, retention, and response to legal and civil matters. Another commenter stated that HHS should not retain PII longer than is necessary to carry out an authorized Exchange function.

Response: While the rule does not specifically mention storage, retention, or response to legal and civil matters, we believe that the final rule adequately addresses privacy and security standards for all potential uses of data, including storage and retention. We therefore do not include these elements in the final rule. We expect privacy and security standards developed by the Exchange will address the storage of information when it is not in use. Also, the Exchange policies and protocols must apply to all requests for information from outside sources, including governmental bodies, the courts, or law enforcement officials. We also believe that Exchanges should not retain PII longer than necessary. Retention times for Federally-facilitated Exchanges will be approved by the National Archives and Records Administration. As these retention times have not yet been issued for these Exchanges, and as we believe that a single standard for retention should apply to all Exchanges, we plan to release guidance on this topic at a later date.

Comment: One commenter asserted that HHS should not create one central location for personal information. The commenter challenged the government's ability to protect personal information.

Response: This comment regarding the storage of personal information is operational in nature and outside the scope of this rule. We plan to release guidance describing the approach for collection and storage of PII. We believe that the privacy and security standards in the final rule are sufficiently robust to protect the types of PII that will be created, collected, used, and disclosed by Exchanges.

Comment: A few commenters suggested that HHS should define the operational solutions for Exchange policies and protocols for privacy and security. One commenter said that Exchanges should create usage logs that are subject to audit to ensure the data are being accessed appropriately and only for business purposes. Another commenter stated that HHS should

implement procedures related to identity theft to address cases where an applicant or enrollee reports that someone has fraudulently submitted information in his or her name. One commenter recommended that HHS collect data in a manner that allows for de-identification so that data can be made available for other purposes, such as research and analysis.

Response: We believe that having policies and protocols to protect against identify theft and fraudulent enrollment is critical. However, setting operational solutions for complying with regulatory standards in this section is outside the scope of the rule. HHS will release guidance identifying potential operational solutions for storing and tracking data, identifying and preventing fraudulent submissions to the Exchange, and de-identifying data.

Comment: A number of commenters recommended that HHS address the issue of authentication of individuals who access PII through the Exchange. One commenter asserted that HHS should ensure that Exchanges authenticate all entities and individuals interacting with the Exchanges. Commenters also cautioned HHS to develop authentication procedures that are minimally burdensome and do not discourage or prevent lawful consumer access to the Exchange. One commenter stated that authentication procedures should be proportionate to the risks associated with the corresponding activities. This commenter also stated that authentication procedures should leverage commercially available database sources, a method currently in use by States to authenticate identity.

Response: Exchanges will need robust authentication procedures that are effective, efficient, and minimally burdensome for both States and individuals. We have added language to the final rule that Exchanges must implement safeguards to ensure that personally identifiable information is disclosed only to those authorized to receive or view it. In addition, we expanded the scope of the privacy and security standards by stating explicitly that these standards must

apply, as a condition of contract or agreement with an Exchange, to individuals or entities, including but not limited to Navigators, agents, and brokers, that: (1) gain access to personally identifiable information submitted to an Exchange; or (2) create, collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.260 of the proposed rule regarding privacy standards, with the following modifications: in an effort to prevent confusion and duplication in terminology, we removed paragraph (a), which defined personally identifiable information (PII) in the context of the Exchange program. This is a term used broadly by all Federal agencies, and the term is defined in a 2007 OMB Memorandum, which we point to in the preceding preamble discussion.

We redesignated proposed paragraph (b) as new paragraph (a). In paragraph (a)(1) of the final rule, we added that, where the Exchange creates or collects personally identifiable information for the purposes of determining eligibility for enrollment in a QHP, determining eligibility for other insurance affordability programs, as defined in §155.20; determining eligibility for enrollment in a qualified health plan; determining eligibility for other insurance affordability programs, as defined in 155.20; or determining eligibility for the exemptions from individual responsibility provisions described in section 5000A of the Code, the Exchange may only use or disclose such personally identifiable information only to the extent such information is necessary to carry out the functions described in §155.200 of this subpart. This paragraph limits the purposes for which the Exchange can use this information to those outlined in

§155.200 of this subpart. Paragraph (a)(2) is broader in scope than the type of PII described in (a)(1), and includes all personally identifiable information collected for the purposes of carrying out Exchange minimum functions described in §155.200. This paragraph prohibits the creation, collection, use or disclosure of PII unless the manner in which the Exchange does so is consistent with the privacy and security standards outlined in §155.260. In the final rule, we removed the provision from proposed paragraph (b)(2) for Exchanges to establish and follow operational, administrative, physical and technical security standards that, if carried out by a HIPAA covered entity would meet the standards at 45 CFR 164.306, 164.308, 164.310, 164.312 and 164.314. In its place we clarify that the Exchange must not create, collect, use or disclose PII unless the manner in which they do so is consistent with the standards of §155.260. In new sections (a)(3)(i) through (viii), we outlined the principles that an Exchange must use in the development of its privacy and security standards. These include individual access; correction; openness and transparency; individual choice; collection, use, and disclosure limitations; data quality and integrity; safeguards; and accountability.

As described in new text added to (a)(4)(i) through (vi), an Exchange must establish and implement a set of operational, technical, administrative and physical safeguards that ensure the confidentiality, integrity, and availability of PII created, collected, used, and disclosed by the Exchange; that personally identifiable information is only used by or disclosed to those authorized to receive or view it; return information, as such term is defined by section 6103(b)(2) of the Code, is kept confidential under section 6103 of the Code; personally identifiable information is protected against any reasonably anticipated threats or hazards to the confidentiality, integrity, and availability of such information; and personally identifiable information is protected against any reasonably anticipated uses or disclosures of such

information that are not permitted or established by law.

New paragraph (a)(5) directs the Exchange monitor, periodically assess, and update the security controls and related system risks to ensure the continued effectiveness of the controls. In new paragraph (a)(6), we added a standard that the Exchange develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.

In new paragraph (b), we added that, except for tax return information, when creation, collection, use, or disclosure is not otherwise required by law, an Exchange must establish the same or more stringent privacy and security standards (as those in §155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that gain access to personally identifiable information submitted to an Exchange; or create, collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

New paragraph (c) directs the Exchange to ensure its workforce complies with the policies and procedures developed and implemented by the Exchange to comply with this section.

In new paragraph (e), we added language to clarify that the standards for data matching and sharing between the Exchanges and Medicaid, CHIP, and BHP, where applicable, are triggered when these entities share PII. In addition, we added paragraph (e)(1) through (e)(4), which state that data matching or sharing agreements must: meet any applicable requirements described in this section; meet any applicable requirements described in sections 1413(c)(1) and (c)(2) of the Affordable Care Act; be equal to or more stringent that the requirements for

Medicaid programs under section 1942 of the Act; and, for those matching agreements that meet the definition of "matching program" under 5 USC 552a(a)(8), comply with 5 USC 552a(o).

In paragraph (g), we added that the civil penalty applies to each instance of knowing and willful improper use or disclosure of information. We redesignated proposed paragraph (b)(4) as new paragraph (d), and redesignated proposed paragraph (d) as new paragraph (f).

i. Use of standards and protocols for electronic transactions (§155.270)

In §155.270 of the proposed rule, we proposed that the Exchange apply the HIPAA administrative simplification standards adopted by the Secretary in accordance with 45 CFR parts 160 and 162 when the Exchange performs electronic transactions with a covered entity. In addition, we proposed to codify the Health Information Technology (HIT) enrollment standards and protocols that were developed in accordance with section 3021 of the PHS Act, which was added by section 1561 of the Affordable Care Act, and that were adopted by the Secretary.[4] Specifically, we proposed that these aforementioned standards and protocols be incorporated within Exchange information technology systems.

Comment: HHS received several comments supporting our proposal to apply HIPAA administrative simplification standards, including the use of national standards and protocols for electronic transactions in §155.270. However, one commenter expressed concern about the potential for gaps in the 005010 standard adopted by the Secretary in accordance with HIPAA. Another commenter, who supported the application of the administration simplification standards, added that HHS should apply any new transaction standards or protocols developed to supplement the HIPAA transactions consistently across all State-based Exchanges to promote administrative simplification among QHP issuers and eligibility services integrated with Exchanges.

[4] http://healthit.hhs.gov/portal/server.pt?open=512&mode=2&objID=3161.

Response: HIPAA administrative simplification standards are the appropriate standards for transactions that occur between the Exchange and covered entities, such as issuers, to continue the promotion of uniformity in administration and information interoperability of the Exchange activities as part of the larger health insurance industry. If Exchanges choose to implement standards in addition to those established in 45 CFR parts 160 and 162, they will continue to be in compliance with the final rule. As we work with Exchanges in connection with the information reporting standards for enrollment purposes to QHP issuers and/or Medicaid and CHIP agencies, we will be mindful of the potential for gaps in the 005010 standard adopted by the Secretary in accordance with HIPAA and will fully adhere to privacy and security standards in §155.260 and §155.270

Comment: One commenter recommended that "operating rules" be included in the phrase "the Exchange must use standards, implementation specifications, and code sets adopted by DHHS" in §155.270(a), noting that proposed §155.240(e) contains language that an Exchange must use "the standards and operating rules referenced in §155.260 and §155.270" when conducting electronic transactions with QHPs involving premium payments or electronic fund transfers.

Response: We accept the commenter's recommendation to add the phrase "operating rules" to the proposed regulation text. In the final rule, we amended §155.270(a) to include the term "operating rules" to address communications involving Exchanges that are subject to HIPAA administrative simplification.

Comment: Several commenters supported §155.270(b) of the proposed rule, which directs an Exchange to incorporate standards developed by the Secretary in accordance with section 1561 of the Affordable Care Act, which amends the PHS Act and directs HHS to develop

interoperable and secure standards and protocols for electronic enrollment transactions in consultation with the HIT Policy and HIT Standards committees. However, some commenters expressed concern about the ongoing usefulness of the committees' recommendations. Two commenters stated that the recommendations of those committees are now outdated. Another stated that a weakness in the cited HIT enrollment standards and protocols is the fact that these standards are not applicable to web services. Commenters noted that these standards and protocols facilitate the transfer of consumer eligibility, enrollment, and disenrollment information, but do not fill the need for standards that would apply to web services versions of HIPAA transactions. One commenter said it is critical that Exchanges design electronic data formatting and transmission standards that are uniform, easily implemented by QHP issuers, and leverage electronic data formatting and transmission standards that are already in use by health insurance carriers. Commenters also suggested that HHS recommend that Exchanges use specific data exchange formats and transmission standards such as those already established under the Health Insurance Portability and Accountability Act of 1996 and by CMS (for example, the 834 Enrollment, Online Enrollment Center (OEC) file format, and Health Plan Management System (HPMS) reporting).

Response: It will be important to leverage electronic data formatting and transmission standards that are already in use. However, we also believe that adhering to the broad standards and protocols developed by the Secretary, in collaboration with the HIT Policy and Standards committees, in accordance with section 3021 of the PHS Act, will provide standardization while allowing for the flexibility to leverage existing standards. We plan to issue guidance to help States determine appropriate transmission standards and data exchange formats for their Exchanges. We will also be consulting with the HIT Policy and HIT Standards committees at

regular intervals to update the cited HIT enrollment standards and protocols to be more applicable to web services and to incorporate updates from Exchange electronic data formatting and transmission standards to broader standardization efforts. We also note that §155.270 controls only how the Exchange sends information electronically to HIPAA covered entities. Section §155.260 addresses privacy and security standards.

Comment: A few commenters expressed concern about the privacy and security of information being shared via electronic transactions in accordance with proposed §155.270. Some commenters requested that this section reference the limitations on use and disclosure in §155.260 of this subpart, which sets privacy and security standards for Exchanges. These commenters also recommended codifying section 1413(c)(1) of the Affordable Care Act, which directs States to develop secure interfaces for electronic data sharing. Another group of commenters expressed concern that co-mingling of data used for different purposes would create threats to the privacy of PII. These commenters requested that HHS ensure that Exchanges maintain a division between information that is stored and information that is used for eligibility determinations and redeterminations, with strict standards for disclosure or release of stored data.

Response: We believe the commenter's suggestion to include a regulatory citation to §155.260 would be redundant because the privacy and security standards and protections in §155.260 will apply to all transactions in which data are created, used, collected, stored, or disposed of by Exchanges. We also note that section 1413(c) of the Affordable Care Act is codified in section §155.260(b)(3) and §155.260(c). In addition, we note that the privacy and security standards cited in §155.260 apply to both stored information and information used for eligibility determinations and redeterminations. Finally, while we acknowledge that stored data and data in active use warrant different privacy and security protocols, we believe that the

privacy and security standards in §155.260 direct Exchanges to have safeguards in place to prevent improper use, collection, or disclosure of information, whether the data are at rest or in transit. We therefore do not think it is necessary to address this distinction in our final regulation.

Comment: One commenter recommended that HHS adopt an operating rule that would apply to web services versions of the HIPAA transactions. This commenter encouraged HHS to consider the CORE Phase II rules, which have significant industry support, and to develop new standards that are not addressed in the CORE Phase II rules.

Response: It is important for HHS to adopt a standard for web-based transactions; however, detailed discussion on the adoption of such standards is outside the scope of this final rule. In this final regulation, we maintain the policy that Exchanges must apply and follow HIPAA standard transactions when engaging in electronic exchanges of information with Covered Entities.

Comment: One commenter requested clarification about whether it was in the intention of HHS to ensure that all electronic transactions with covered entities be consistent with the standards of 45 CFR parts 160 and 162. The commenter stated that this would direct all Medicaid agencies and issuers to use only standard transactions when conducting electronic transactions with Exchanges. Further, if it is the intent of HHS to permit, rather than require, these entities to conduct standard transactions with Exchanges, the commenter expressed that proposed §155.270(a) should be rewritten to state this clearly. In addition, this commenter requested that HHS clarify whether Exchanges must conduct standard transactions with non-covered entities, such as employers and banks or their respective agents that request to do so. This clarification would ensure that employers and others that are now conducting (or may in the future conduct) such standard transactions as eligibility for a health plan, enrollment or

disenrollment in a health plan, or health plan premium payments may be assured they can do so as standard transactions with exchanges.

Response: It is the intention of HHS to require, rather than to permit, adherence to the standards, implementation specifications, and code sets adopted by the Secretary in 45 CFR parts 160 and 162, but only to the extent that the Exchange is performing electronic transactions with a covered entity. It is not the intention of HHS to establish standardized HIPAA transactions when Exchanges perform electronic transactions with non-covered entities, such as employers or banks. However, the Exchange has the flexibility to choose to use those standards, even if they are not minimum standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.270 of the proposed rule, with the following modification: in paragraph (a), we added a provision for Exchanges to use the operating rules adopted by the Secretary in 45 CFR parts 160 and 162.

4. Subpart D -- Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

In this subpart, we proposed standards that the Exchange will use to determine eligibility for Exchange participation and insurance affordability programs. In the proposed rule and in this final rule, we organized the standards as follows: eligibility standards, eligibility determination process, and applicant information verification process.

a. Definitions and general standards for eligibility determinations (§155.300)

In §155.300, we proposed definitions for this subpart. Virtually all of the definitions proposed in this section were taken from other proposed regulations, including the Exchange establishment proposed rule which was published prior to the Exchange eligibility proposed rule.

Specifically, in this section, we proposed definitions or interpretations for "adoption taxpayer identification number," "applicable Medicaid modified adjusted gross income (MAGI)-based income standard," "applicable CHIP modified adjusted gross income (MAGI)-based income standard," "application filer," "Federal Poverty Level," "Indian," "insurance affordability programs," "minimum value," "non-citizen," "primary taxpayer," "State CHIP Agency," "State Medicaid Agency," and "tax dependent." We also proposed rules related to the applicability of Medicaid and CHIP rules and the acceptance of attestations.

Comment: A few commenters discussed the use of the term "MAGI" in the proposed rule. A commenter recommended referencing the term "MAGI-based standard for Medicaid and CHIP," as defined in the Medicaid proposed rule, and the term "MAGI," as defined in the Treasury proposed rule. One commenter also asked that the differences in the use of MAGI for Medicaid eligibility, such as income exemptions described in the Medicaid proposed rule, be specified in §155.300.

Response: We recognize the need to reference the definitions of "MAGI" and "MAGI-based income" in §155.300(a), and in this final rule include a reference to MAGI, as defined in 36B(d)(2)(B) of the Code, and MAGI-based income, as defined in 42 CFR 435.603(e). To clarify, we use "MAGI" with respect to household income for advance payments of the premium tax credit and cost-sharing reductions, and "MAGI-based income" with respect to household income for Medicaid and CHIP. We note that to further clarify this, we have added cross-references whenever "household income" is used throughout this subpart to specify whether it is in reference to household income for purposes of advance payments of the premium tax credit and cost-sharing reductions, as defined in section 36B(d)(2) of the Code, or household income for purposes of Medicaid and CHIP, as defined in 42 CFR 435.603(d).

Comment: We received a number of comments regarding the definition of Federal Poverty Level (FPL), as proposed in §155.300(a). The definition, as proposed, specified that the FPL table used for eligibility for advance payments of the premium tax credit and cost-sharing reductions for a coverage year must be the table published as of the first day of Exchange open enrollment for the coverage year; commenters recommended that this definition be aligned with the definition of FPL used for Medicaid and CHIP eligibility, which uses the FPL table available at the time of an eligibility determination.

Response: We acknowledge the commenters' concerns. However, section 36B(d)(3) of the Code, as added by section 1401(a) of the Affordable Care Act, clearly defines the FPL table that must be used for eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions in such a way that it is distinct from the FPL table that is used for Medicaid and CHIP eligibility during much of the year. Therefore, HHS will maintain the proposed definition of FPL in the final rule. To the definition of "Federal poverty level", we also included " or FPL"; throughout the final rule we also remove references to Treasury regulations when using the term FPL since the term is defined in this section using the same definition as in section 36B of the Code.

Comment: We received many comments asking HHS to define "incarcerated, other than pending the disposition of charges" in proposed §155.300. Several commenters also recommended that such a definition be similar to the definition of "inmate of a public institution," as used by the Medicaid program (42 CFR 435.1010).

Response: We acknowledge commenters' suggestion that we further define the term "incarcerated, other than pending the disposition of charges," as used in §155.305(a)(2), and we intend to clarify this term in future guidance. We note that 42 CFR 435.1010 defines the term

"inmate of a public institution", which is broader than the term "incarcerated" as used in this part; therefore, we do not have the authority or reason to adopt the broader definition, as the term "incarcerated" is used in the statute.

Comment: Commenters asked that we amend our definitions of "State Medicaid Agency" and "State CHIP Agency" to explicitly include those offices that administer them in the U.S. Territories.

Response: We acknowledge the suggestion, but are maintaining the proposed definitions in the final rule. These definitions reference Medicaid and CHIP regulations, which address Territories separately. Furthermore, the definition of "State" as included in section 1304(d) of the Affordable Care Act does not include Territories, and since this final rule implements only certain provisions of Title I of the Affordable Care Act that relate to States and Exchanges, we do not include Territories in these definitions.

Comment: We received several comments providing alternative interpretations of the definition of "Indian" than that which was included in the Exchange establishment and eligibility proposed rules. Some commenters suggested our definition is too narrow and inconsistent with Federal law. One commenter recommended that Indian be defined as a person who is a member of an Indian tribe or any person who is a member of an Indian tribe as defined in subsection (d) of the Indian Health Care Improvement Act (IHCIA), not limited to only Federally-recognized tribes. Other commenters stated that they believed that HHS's interpretation is not supported by the plain language of section 4 of IHCIA or section 4(d) of the Indian Self-Determination and Education Assistance Act (ISDEAA) and believe that it is contrary to general principles of Indian law. Several commenters recommend that at a minimum HHS recognize that the definitions under the ISDEAA and IHCIA are operationally the same. Several commenters

recommend that this rule align its definition with the Medicaid/CHIP definition found in 42 CFR 447.50.

Response: Since the Affordable Care Act statutory provisions identifying the specific benefits available to Indians incorporate section 4 of the IHCIA (for purposes of the special enrollment period described in §155.420(d)(8)) and section 4(d) of the ISDEAA (for purposes of the cost-sharing provisions described in §155.300(a) and (b)) for the definition of Indian, we are unable to adopt the Medicaid/CHIP definition under 42 CFR 447.50. Therefore, we maintain our proposed definition in this final rule. However, since both the ISDEAA and IHCIA operationally mean the same thing, there is uniformity among the definition of Indian for purposes of the Exchange-related benefits described in this final rule. We accept that the definitions of "Indian" as provided under section 4(d) of ISDEAA (codified at 25 U.S.C. 450 et. seq.) and section 4 of IHCIA (codified at 25 U.S.C. 1603) operationally mean the same thing: an individual who is a member of an Indian tribe. In their definitions of an "Indian tribe," both of these acts have nearly identical language that refers to a number of Indian entities (tribes, bands, nations, or other organized groups or communities) that are included in this definition on the basis that they are "recognized as eligible for the special programs and services provided by the United States to Indians because of their status as Indians."

Comment: One commenter asked that we clarify that the use of "attestation" does not prohibit the Exchange from obtaining electronic data and then asking an applicant to validate it, with the goal of increasing the efficiency and accuracy of the eligibility process.

Response: A key principle in our approach to the eligibility process is to streamline this verification process and maximize the use of electronic data. In many cases, we anticipate that the dynamic, electronic application process will take the approach that is recommended by the

commenter. In other cases, it will be necessary to obtain information prior to verifying it. In general, the language of the final rule does not mandate a specific sequencing of activities, and is designed to allow flexibility within standards to ensure that the eligibility process can evolve to align with changes in technology and the availability of authoritative data. We also note that we will be providing a model application, which will include sequencing for the various steps needed in the eligibility process. Consequently, we are maintaining the language from the proposed rule. We look forward to working closely with States to achieve our shared goal of a streamlined eligibility process, including through the many areas in which we are providing flexibility to allow for continuous quality improvement in access to affordable health insurance.

We note that we have removed the language that specified that additional individuals, including a parent, caretaker or someone acting responsibly on behalf of such an individual, could provide attestations. The definition of application filer, which is now located in §155.20, includes references to all individuals who may provide attestations; applicants, authorized representatives, and if the applicant is a minor or incapacitated, someone acting responsibly on behalf of the applicant. We have also replaced all references in this subpart regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

Comment: We received comment regarding our definition of primary taxpayer. A commenter expressed concern that an individual may not know his future filing status.

Response: While this final rule revises the term “primary taxpayer” to “tax filer,” to incorporate both spouses in a situation in which a married couple is filing jointly, we keep the proposed definition with minor revisions. Section 36B of the Code governs eligibility for the

premium tax credit and advance payments of the premium tax credit, and specifies that it is based on the annual household income for a tax family for the year for which coverage is requested, which necessitates an understanding of an applicant's expected tax household for such year. We acknowledge challenges in communicating with individuals during the application process, including regarding tax filing status, and intend to work closely with stakeholders to develop effective communication strategies and tools.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.300 of the proposed rule, with the following modifications:

We removed the definition of "application filer," and moved the definition to §155.20, as a definition applicable for all of part 155; we address this change in comment response for §155.20. In the definition of "applicable CHIP MAGI-based income standard," we changed the reference from 42 CFR 457.05(a) to 42 CFR 457.310(b)(1) to align with the Medicaid final rule. For the definition of "minimum value", we clarified that the definition is used to describe coverage in an eligible employer-sponsored plan, and that minimum value means that an eligible employer-sponsored plan meets the standards with respect to coverage of the total allowed costs of benefits set forth in section 36B(c)(2)(C)(ii) of the Code. We added language to the definition of "State Medicaid agency" to clarify that the State Medicaid agency may be established or designated by the State in accordance with Medicaid regulations. For the definition of "insurance affordability program" we cross-referenced 42 CFR 435.4, but clarify that those programs included in this definition are the State Medicaid program under Title XIX of the Act, CHIP under Title XXI of the Act, the BHP under section 1331 of the Affordable Care Act, advance payments of the premium tax credit under section 36B of the Code, and cost-sharing reductions

under section 1402 of the Affordable Care Act.

As further explained in response to comments later in §155.305, we also changed the definition of "primary taxpayer" to "tax filer," which reflects that the role includes either spouse in a joint-filing situation, and changed the term throughout the subpart. Within the definition, we also added "or a married couple," to clarify that a tax filer may be an individual or a married couple, and deleted subparagraph (1)(iv), which included language clarifying that a primary taxpayer could be either spouse in a married couple, as this language is now redundant. In paragraph (a), we added a definition for "modified adjusted gross income" and a definition of "MAGI-based income." We also change the rule described in paragraph (b) to clarify that the Medicaid and CHIP regulations referred to in this subpart will be implemented in accordance with the policies and procedures as applied by the State Medicaid or State CHIP agency or as approved by the agency in the agreement described in 155.435(a). In response to comments, we also added new paragraph (d), which describes a rule for the Exchange when determining whether information is "reasonably compatible"; this clarification is discussed in more detail in §155.315 comment response.

We also made technical changes to this section. In paragraph (c), we changed the reference to §155.310(e)(2)(ii) to §155.310(d)(2)(ii). For the definition of "applicable Medicaid MAGI-based income standard," we changed the reference to 42 CFR 435.1200(c)(3) to 42 CFR 435.1200(b)(2).

Lastly, throughout this subpart, we have removed cross-references to the Treasury proposed rule and replaced them with cross-references to the applicable language in section 36B of the Code, as added by section 1401(a) of the Affordable Care Act, as the Treasury proposed rule will not be finalized as of the publication of this rule. Upon publication of the Treasury final

rule, we intend to replace the statutory references with the appropriate regulatory references.

b. Options for conducting eligibility determinations (§155.302)

Based on comments and feedback to the proposed rule, we are revising the rule to include this section as an interim final provision, and we are seeking comments on it.

Comment: We received a number of comments expressing support for a policy in which eligibility processes were integrated across the Exchange, Medicaid, and CHIP in order to ensure a seamless experience for consumers. Commenters further stressed the importance of a single entity conducting all eligibility determinations. We also received comments asking that States be permitted to rely on the Federal government for certain eligibility functions, and that State Medicaid and CHIP agencies be permitted to exercise final control over eligibility determinations for Medicaid and CHIP based on applications submitted to the Exchange, particularly when the State does not operate an Exchange. In particular, commenters asked that the Federal government offer to perform eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, based on an argument that this is not a current part of State processes, should be uniform across States, and is connected to the advance payment of premium tax credits with Federal funds. Another commenter suggested that rather than have the Federal government assume responsibility for an entire eligibility function, we should isolate certain components of the eligibility function.

Response: While a fully-integrated eligibility process will best achieve a seamless experience for applicants, we adopt the suggestion of the commenters who requested a more flexibility for States regarding Medicaid and CHIP eligibility determinations. With appropriate standards, this approach could both maintain the seamless consumer experience while allowing States to design the eligibility process to best match their current systems and capacity.

Accordingly, while the majority of subpart D continues to refer to all functions being carried out by the Exchange, in new §155.302 of this final rule, we specify that the Exchange may fulfill these provisions through different options or combinations of options, subject to standards described in §155.302(d). The standards in §155.302(d) are intended to ensure that this approach to eligibility determinations still affords applicants a seamless path to enrollment in coverage and that it does not increase administrative burden and costs; we use certain performance standards identified in paragraphs (b), (c) and (d) and the agreements among the relevant agencies to achieve this. We clarify that these options are separate and distinct from the "State Partnership" model described in the preamble of §155.200 of this final rule. We intend to provide further guidance on the implementation of these options, including the roles and responsibilities of the various parties, in the future.

First, in §155.302(a), we clarify that the Exchange may fulfill its minimum functions under this subpart by either executing all eligibility functions, directly or through contracting arrangements described in §155.110(a), or through one or both of the approaches identified in paragraphs (b) and (c) when other entities determine the eligibility of applicants for insurance affordability programs.

Second, in §155.302(b), we identify that the Exchange may conduct an assessment of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP. Such an arrangement is permissible provided that 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 Medicaid and CHIP regulations, without regard to how such standards are implemented by the State Medicaid and CHIP agencies. That is, the assessment must follow verification rules and

procedures that could be adopted by a State Medicaid or CHIP agency, although the use of this option is not contingent on the State Medicaid or CHIP agency doing so.

In paragraph (b)(2), we provide that notices and other activities that must be conducted in connection with an eligibility determination for Medicaid or CHIP are conducted by the Exchange consistent with the standards identified in this subpart or by the applicable State Medicaid or State CHIP agency consistent with applicable law.

In paragraph (b)(3), we outline the procedures the Exchange must follow when, based on the assessment conducted consistent with the standards in paragraph (b)(1), the Exchange finds an applicant potentially eligible for Medicaid or CHIP. We note that "potentially eligible" does not mean that the individual's income, as determined by the Exchange, necessarily is at or below the applicable Medicaid or CHIP MAGI-based income standard. We would expect in the interagency agreements between the State Medicaid and CHIP agencies and the Exchange, the Exchange's determination of which applications will be transferred for further action by the Medicaid and CHIP agencies will depend in part on the extent to which their verification procedures are consistent with those followed by the State Medicaid and CHIP agencies. The Exchange would transmit such an individual's information to the State Medicaid or CHIP agency in accordance with paragraph (b)(3) for additional processing, although the Exchange would consider him or her as ineligible for Medicaid or CHIP for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions until the State Medicaid or CHIP agency notified the Exchange that the individual was eligible for Medicaid or CHIP. We will work with Exchanges to establish a reasonable application of the term "potentially eligible" taking into account an Exchange's assessment procedures.

In paragraph (b)(4), we describe the procedures that the Exchange must follow when, based on an assessment conducted in accordance with paragraph (b)(1), the Exchange 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 such an applicant as ineligible for Medicaid or CHIP for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, and notify the applicant and provide him or her with the opportunity to withdraw his or her application for Medicaid and CHIP. To the extent that an applicant withdraws his or her application for Medicaid and CHIP (for example, if he or she is approved for advance payments based in part on an assessment that he or she is not potentially eligible for Medicaid and CHIP), the applicant would not receive a formal approval or denial of Medicaid and CHIP; the alternative is for the applicant to request that the Exchange transmit the application to the State Medicaid and CHIP agency for additional processing.

As noted above, in addition to providing the applicant with the opportunity to withdraw his or her application for Medicaid and CHIP, in paragraph (b)(4)(i)(B), the Exchange must notify and provide the applicant with the opportunity to request a full determination of eligibility for Medicaid and CHIP by the applicable State Medicaid and CHIP agencies. For an applicant who requests a full Medicaid and CHIP determination, the Exchange must transmit all information as provided as part of the application, update, or renewal that initiated the assessment and any information obtained or verified by the Exchange to the State Medicaid and CHIP agency. The Exchange must also consider such an applicant as ineligible for Medicaid or 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 has been determined eligible for Medicaid or CHIP.

The arrangement under paragraph (b) would also provide that the Exchange must adhere to the eligibility determination made by the Medicaid or CHIP agency, and that the Exchange and the applicable State Medicaid and CHIP agencies enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We expect that these agreements will establish the responsibilities across the parties, and we will work with States to help develop such agreements. We note that we include rules related to assessments of eligibility for Medicaid and CHIP in paragraph (b)(1), to reinforce this concept. The standards and responsibilities of the Exchange, which we include for this agreement, complement the standards in 42 CFR 435.1200(d) of the Medicaid final rule. In accordance with these standards, we expect that when an assessment is conducted by the Exchange and transmitted to the State Medicaid or CHIP agency, and the Exchange is providing advance payments pending an eligibility determination for Medicaid and CHIP, the Exchange will receive a notification of the final determination of eligibility for Medicaid and CHIP made by the receiving agency. Together, these standards aim to avoid the duplication of requests for information from applicants and verification of information, and ensure timely eligibility determinations despite the 'hand-offs' to different agencies or entities. Furthermore, we believe the inclusion of the functions and the standards for the agreements described in §155.302 are consistent with our goal of ensuring a seamless eligibility process. We also note that while defining what constitutes eligibility for minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions is outside the scope of this regulation, we clarify that our understanding is that if the Exchange conducts an assessment in accordance with paragraph (b) of this section and does not find that an applicant is

eligible for Medicaid and CHIP, such finding is sufficient to meet the eligibility criteria specified in §155.305(f)(1)(ii)(B) with respect to Medicaid and CHIP.

Third, in §155.302(c) of the final rule, we describe that the Exchange must implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions made by HHS. We also describe that such an arrangement must provide that all verifications, notices, and other activities conducted in connection with determining eligibility for advance payments of the premium tax credit and cost-sharing reductions are conducted by either the Exchange in accordance with all of the applicable standards described in this subpart or by HHS in accordance with the agreement between HHS and the Exchange. We also direct that the Exchange transmit all applicant information and other information obtained or verified by the Exchange to HHS. The Exchange would then adhere to HHS's determination for advance payments of the premium tax credit and cost-sharing reductions. The Exchange and HHS would also need to 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. As with the option described in §155.302(b), we include particular standards and responsibilities which are designed to eliminate duplicative requests for information from applicants and ensure timely eligibility determinations.

In §155.302(d) we outline the standards to which the Exchange must adhere when assessments of eligibility for Medicaid and CHIP based on MAGI and eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions are made in accordance with paragraphs (b) and (c); such standards include that all eligibility processes are streamlined and coordinated across applicable agencies, that such arrangement does not increase administrative costs and burden on applicants, enrollees, beneficiaries, or application filers, or

increase delay, and that applicable requirements under part 155 and section 6103 of the Code are met.

Lastly, we note that all of the above configuration options will necessitate coordination between the Exchange, HHS, and the State Medicaid and CHIP agency. We will work closely with States to develop operational solutions that will result in a high-quality eligibility process, which in turn will result in achievement of our shared coverage goals and a sustainable Exchange.

Summary of Regulatory Changes

We are finalizing the following provisions at §155.302 and requesting comment. In paragraph (a), we provided that the Exchange may choose to satisfy the standards of subpart D directly or through contracting arrangements, or through one or a combination of options described in paragraphs (b) and (c), subject to additional standards outlined in paragraph (d).

If the Medicaid or CHIP agency retains final control of eligibility determinations for Medicaid and CHIP, in paragraph (b), we described that notwithstanding the standards of this subpart the Exchange may conduct assessments of eligibility for Medicaid and CHIP based on MAGI rather than the eligibility determinations for Medicaid and CHIP provided that: 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; notices and other activities conducted 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; when the Exchange assesses an individual as potentially

eligible for Medicaid or CHIP, 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 or CHIP agency via secure electronic interface; when the Exchange finds an individual not potentially eligible for Medicaid and CHIP, the Exchange considers 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 either withdraw his or her application for Medicaid and CHIP or request a full determination of eligibility for Medicaid or CHIP by the State Medicaid and CHIP agencies. When an applicant requests a full determination of eligibility for Medicaid and CHIP, the Exchange must transmit all information obtained or verified by the Exchange to the State Medicaid and CHIP agencies promptly and without undue delay and 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. Furthermore, under the arrangement described in paragraph (b), the Exchange must adhere to the eligibility determination for Medicaid or CHIP made by the State Medicaid or CHIP agency, and the Exchange and the State Medicaid and CHIP agencies must enter into an agreement specifying their respective responsibilities in connection with eligibility determinations for Medicaid and CHIP. We note that in such an arrangement if the Exchange the State Medicaid and CHIP agencies are using the same information technology infrastructure formal transmissions may not be needed.

In paragraph (c), we establish that notwithstanding the standards 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. Under such option we provide: that verifications, notices, and other activities necessary 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 between the Exchange and HHS; 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; the Exchange adheres to the eligibility determination for advance payments of the premium tax credit and cost-sharing reductions made by HHS; and 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.

In paragraph (d), we outline the standards to which assessments and eligibility determinations described in paragraph (b) and (c) must adhere, including that eligibility processes are streamlined and coordinated across insurance affordability programs; such arrangement does not increase administrative costs and burdens on individuals or increase delay; and any applicable standards under §155.260 or §155.270, §155.315(i), and section 6103 of the Code with respect to the confidentiality, disclosure, maintenance, or use of information will be met. All such changes adopted for this section of the final rule are described in responses to comments for §155.302.

c. Eligibility standards (§155.305)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it.

In §155.305, we proposed to codify the eligibility standards for enrollment in a QHP and for insurance affordability programs. Specifically, we proposed that the Exchange determine an applicant eligible for enrollment in a QHP if he or she meets the basic standards for enrollment in a QHP outlined in the Affordable Care Act, including that the individual must be a citizen, national, or a non-citizen who is lawfully present, not incarcerated, and be reasonably expected to remain so for the entire period for which enrollment is sought. We solicited comments regarding the language that an individual be "reasonably expected," for the entire period for which enrollment is sought, to be a citizen, national, or non-citizen lawfully present, and on how this policy can be implemented in a way that is straightforward for individuals to understand and for the Exchange to implement.

We also proposed that in order to be eligible to enroll in a QHP, an individual must intend to reside in the State in the service area of the Exchange. We clarified that this residency standard is designed to apply to all Exchanges, including regional and subsidiary Exchanges. In general, we proposed to align the Exchange residency standard with the Medicaid residency standards proposed in 42 CFR 435.403 of the Medicaid proposed rule (76 FR 51148). We clarified that this residency standard does not require an individual to intend to reside for the entire benefit year. We also proposed that the Exchange follow additional Medicaid residency standards (which were proposed in the August 17, 2011 Medicaid rule at 42 CFR 435.403) and the policy of the State Medicaid or CHIP agency to the extent that an individual is specifically described in that section and not under paragraphs (a)(3)(i) or (ii).

We proposed that for a spouse or a tax dependent who resides outside the service area of the tax filer's Exchange, the spouse or tax dependent will be permitted to either: (1) enroll in a QHP through the Exchange that services the area in which he or she resides or intends to reside;

or (2) enroll in a QHP through the Exchange that services the area in which his or her tax filer intends to reside or resides, as applicable. We also solicited comment on any standards regarding in-network adequacy for out-of-State dependents that we should consider in a different section of the proposed rule. We also noted that that HHS intends to allow State Medicaid agencies to continue to have State-specific rules with respect to residency for students under the Medicaid program, and solicited comments on whether different residency rules should be maintained for enrollment in a QHP or whether a unified approach should be adopted.

We proposed that the Exchange 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. We also proposed that the Exchange determine applicants' eligibility for Medicaid and CHIP. Specifically, we proposed that the Exchange determine eligibility for Medicaid based on categories utilizing the applicable Medicaid MAGI-based income standard, and that the Exchange determine eligibility for CHIP if an applicant meets the standards of 42 CFR 457.310 through 457.320 and has a household income within the applicable CHIP MAGI-based income standard. Additionally, we proposed to codify that if a BHP is operating in the service area of the Exchange, the Exchange will determine an applicant's eligibility for the BHP, using the statutory criteria for eligibility.

We also proposed that the Exchange determine eligibility for advance payments of the premium tax credit based on eligibility standards proposed in paragraph (f)(1) and (f)(2), and that the Exchange may provide advance payments of the premium tax credit only for an applicant who is enrolled in a QHP through the Exchange. Additionally, we clarified that the Exchange must determine a tax filer ineligible to receive advance payments of the premium tax credit if HHS notifies the Exchange that the tax filer or his or her spouse received advance payments for a

prior year for which tax data would be utilized for income verification and did not comply with the requirement to file a tax return and reconcile the advance payments of the premium tax credit for such year. In the event the Exchange determines that a tax filer is eligible to receive advance payments of the premium tax credit, we proposed that the Exchange calculate advance payments of the premium tax credit in accordance with 26 CFR 1.36B-3 of the Treasury proposed rule (76 FR 50931).

We also proposed that the Exchange require an application filer to provide the social security number (SSN) of the tax filer if an application filer attests that the tax filer has a SSN and filed a tax return for the year for which tax data would be utilized for verification of household income and family size. We solicited comments on how the Exchange can maximize the accuracy of the initial eligibility determination and establish a robust process for individuals to report changes in income to alleviate stakeholder concerns about income fluctuations during the year that may result in large reconciliation payments.

Finally, we proposed that the Exchange must determine applicants eligible for cost-sharing reductions based on eligibility standards described in paragraph (g), and we note that special eligibility standards for cost-sharing reductions based on Indian status are described in §155.350 of this subpart. Specifically, we clarified in the proposed rule that an individual with household income that exceeds 250 percent of the FPL who is not an Indian is not eligible for cost-sharing reductions. We codified the statute such that an applicant must be enrolled in a QHP in the silver level of coverage in order to receive cost-sharing reductions. Lastly, we proposed three eligibility categories for cost-sharing reductions, and proposed that the Exchange transmit information about an enrollee's category to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of reductions.

Comments: We received comments regarding the provision in proposed §155.305(a)(1) which states that an individual must be "reasonably expected" to be a citizen, national, or a non-citizen who is lawfully present for the entire period for which enrollment is sought. One commenter recommended that the final rule remove the "reasonably expected" standard as it would limit non-citizens' eligibility to enroll in a QHP.

Response: The final rule maintains the "reasonably expected" standard in accordance with section 1312(f)(3) of the Affordable Care Act. We do not interpret this provision to mean that an applicant must be lawfully present for an entire coverage year; rather, we anticipate that the verification process will address whether an applicant's lawful presence is time-limited, and if so, the Exchange will determine his or her eligibility for the period of time for which his or her lawful presence has been verified. We anticipate providing future guidance on this topic, with a focus on minimizing administrative complexity and burden.

Comment: We received a number of comments related to and in support of the eligibility standard in proposed §155.305(a)(2) that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, with the exception of incarceration pending the disposition of charges. Several commenters expressed concerns and provided recommendations about how to coordinate and promote continuity of care for individuals who will be transitioning from incarceration, and some commenters expressed this concern in regard to specific populations of incarcerated individuals. One commenter recommended that prisoners should be able to apply for coverage through the Exchange in advance of their release so that coverage can be effective on their release date, while another commenter noted that we should provide that Exchanges must accept applications in the event they are submitted on behalf of an inmate of a correctional facility. Also, one commenter suggested that prisoners should not be held responsible for

reporting changes if they become incarcerated, and prisoners should not be held liable for repayment of advance payments of the premium tax credit for which they would be liable if they are receiving them and then become incarcerated.

Response: In §155.305(a)(2) of the proposed rule, we codified section 1312(f)(1)(B) of the Affordable Care Act, which specifies that in order to be eligible for enrollment in a QHP, an individual must not be incarcerated, other than incarceration pending the disposition of charges. HHS will consider commenters' recommendations related to promoting continuity of care for individuals leaving incarceration in future guidance. Since the Exchange will accept applications and make eligibility determinations throughout the year, an inmate would not be precluded from applying for coverage through the Exchange in an effort to coordinate an effective date of coverage with his or her release date. We also note that §155.420(d)(7) provides a special enrollment period ("A qualified individual or enrollee who gains access to new QHPs as a result of a permanent move") which covers individuals who are released from incarceration.

The final rule maintains the provision specifying that an enrollee must report any change with respect to the eligibility standards in §155.305, which includes when an enrollee becomes incarcerated, other than incarceration pending the disposition of charges, as it is important for the Exchange to be able to discontinue the enrollment and recompute any advance payments or cost-sharing reductions to account for the change in eligibility. As with other changes that affect eligibility for enrollment in a QHP, not reporting such a change so that advance payments of the premium tax credit can be adjusted accordingly exposes a tax filer to the risk of repayment of advance payments of premium tax credits at tax filing.

In addition, we note that we clarify in §155.330(b)(4) of the final rule that an application filer may report a change on behalf of an enrollee, which, for example, allows a member of an

enrollee's household to report the enrollee's incarceration. Also, in §155.330(d)(2) of this final rule, we allow for flexibility for Exchanges to periodically check trusted data sources, provided that the data matching program meets certain standards; this provision could allow an Exchange to engage in data matching on incarceration to provide an additional avenue to capture changes.

Comment: We received a number of comments related to the residency standards for enrollment in a QHP, described in proposed §155.320(a)(3). Several commenters recommended that the residency standards across the Exchange, Medicaid and CHIP be aligned and uniform so as to limit States' discretion in precluding certain transient populations from having continuous coverage throughout the year. Several commenters recommended that we align with the Medicaid "intent to reside" standard, and include the two provisions from the residency standard as proposed in the Medicaid proposed rule at 42 CFR 435.403(h)(1)(ii). One commenter suggested that we add the following alternative as a means of satisfying the residency standard: "Has entered the State with a job commitment (whether or not he or she is currently employed)." A few commenters recommended that we should adopt a more stringent residency standard than included in the Medicaid proposed rule.

Response: We intend to align the residency standards with those of the Medicaid regulations; therefore, we are revising §155.305(a)(3) in this final rule in response to commenters' recommendations that we align residency standards with Medicaid and CHIP and in consideration of changes made from the Medicaid proposed rule to the Medicaid final rule. For example, in §155.305(a)(3)(i)(B), this final rule provides that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not the applicant is currently employed). This provision was included in the Medicaid proposed rule and is included in the Medicaid final

rule; we include it here to provide consistency between these rules. We add language throughout §155.305(a)(3) to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards, to clarify that an individual must be physically present in the service area of the Exchange in order to be eligible for enrollment in a QHP through that Exchange. We note, however, that this does not preclude an individual from submitting an application and receiving an eligibility determination in advance of relocating to a new State; in such a situation, his or her eligibility will not be effective until he or she is "living" in the new State. We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule.

Comment: We received a number of comments related to the proposal in §155.305(a)(3)(iv) related to residency standards for family members who meet the applicable residency standard for a different Exchange service area than of one or both of the tax filers. While several commenters supported the provision in the proposed rule that dependents and spouses may enroll in a QHP offered through the Exchange in the service area where they reside or through the Exchange serving the area where a tax filer meets the applicable residency standard (or in the case of a spouse who is married filing jointly, another tax filer meets the applicable residency standard), several commenters opposed this provision. If this policy is maintained, one commenter recommended that HHS develop a system for Exchanges to easily apportion premium tax credits among family members. Several commenters expressed concern that a person who purchases coverage from a QHP offered through the Exchange where he or she does not live would likely encounter difficulties in finding care as well as significant additional costs from the use of out-of-network providers. In addition, the QHP issuer would be limited in its ability to facilitate use of the highest quality and most efficient providers and coordinate care

across providers and settings. Commenters encouraged HHS to consider limiting this option. Several commenters recommended that HHS establish an electronic mechanism for Exchanges to communicate with each other, as well as sought clarification about how the Exchanges will coordinate tax credits for members of the same tax household purchasing coverage in QHPs through different Exchanges and other specific operational details around verification and the eligibility process. One commenter noted that this would be a simpler process if a tax filer could purchase coverage for a dependent or spouse in the other State's Exchange through the tax filer's Exchange via a link or web portal.

Response: We maintain the residency standard in §155.305(a)(3)(iv) of the final rule with limited modifications. All of the modifications result from a change in our terminology from "primary taxpayer" to "tax filer" in an effort to reduce confusion that could be associated with the term "primary taxpayer," notably since primary taxpayer generally refers to the first name on the tax return of two individuals who are married, but both individuals are tax filers and there is no significance to which is the primary taxpayer for purposes of the premium tax credit (this change has been made throughout the final rule). The remaining changes are to clarify that any member of a tax household that has members in multiple Exchange service areas may enroll in a QHP through any of the Exchanges for which one of the household's tax filers meets the applicable residency standard; the exception to this standard is that when both tax filers enroll in a QHP through the same Exchange, the tax filers' dependents may choose either the Exchange through which the tax filers are enrolled or an Exchange for which the dependents meet the applicable residency standard in paragraphs (a)(3)(i)-(iii). Taken together, we expect that these residency standards will ensure that enrollees in QHPs through the Exchange have appropriate access to services.

Regarding comments suggesting that Exchanges should be able to apportion premium tax credits among family members, we will provide additional information in the future in coordination with the IRS. We note that the apportionment of advance payments will need to occur when a single tax household is covered by more than one QHP. Regarding comments we received related to network adequacy, a more detailed response is provided in §156.230 of this final rule. We also note that multi-State plans certified by and under contract with the Director of the Office of Personnel Management may provide another option in such scenarios. In response to comments recommending that we create an electronic mechanism by which Exchanges can communicate with each other and other operational details of the eligibility process, HHS is considering commenters' recommendations regarding how best to coordinate cross-Exchange activities.

Comment: A few commenters strongly supported limiting enrollment to a single open enrollment period per year.

Response: The language in §155.305(b) of the proposed rule specified that the Exchange determine an applicant eligible for an enrollment period in accordance with the provisions regarding enrollment periods in §155.410 and §155.420.

Comment: A number of commenters expressed overall support for the Exchange conducting Medicaid and CHIP eligibility determinations, and some suggested that the regulation be amended to include a standard that an Exchange determine eligibility for Medicaid on any basis of eligibility offered in that State (such as optional eligibility categories and categories that do not use the MAGI standard). Some commenters expressed support for uniformity and standardization around eligibility and enrollment in general. Several commenters recommended that HHS provide that the Exchange must collect information related to non-

MAGI eligibility to ensure that applicants can truly avail themselves of a "no wrong door" application process for Medicaid. A few commenters supported the clarification that eligibility for emergency Medicaid services does not count as Medicaid eligibility for purposes of eligibility for premium tax credit and cost-sharing reductions through the Exchange. Another recommended that there should be an emphasis on child-only plans through the Exchange for those children who are not eligible for Medicaid.

Response: Sections 155.345(b) and (d) of the final rule specify that the Exchange must assess information provided by an applicant who is not eligible for Medicaid based on standards specified in §155.305(c) to determine whether he or she is potentially eligible for Medicaid in a category that does not use the MAGI standard, and refer any potentially eligible individuals to the Medicaid agency for an eligibility determination. In addition, §155.345(c) of the final rule specifies that the Exchange must provide an opportunity for an applicant to request a full Medicaid eligibility determination based on factors not considered in §155.305(c). We believe that this proposal creates a streamlined eligibility process for the vast majority of applicants, while also allowing applicants who may be eligible for a category that does not use the MAGI standard to access a more streamlined process than is available today, without requiring the Exchange to accommodate all of the complexity associated with the categories of Medicaid that were not modified by the Affordable Care Act.

In order to maintain a single, streamlined application, and in accordance with section 1413(b)(2) of the Affordable Care Act, applicants will not be asked for more information than is needed for the Exchange to make an eligibility determination for insurance affordability programs based on MAGI, apart from collecting basic information to assess individuals for potential Medicaid eligibility on a non-MAGI basis, for example a single triggering question.

Applicants will always have the opportunity to request a full determination of eligibility for Medicaid. We also note that we know that several States are considering leveraging a single Exchange/Medicaid/CHIP technology platform in future years to also accommodate non-MAGI Medicaid applicants, which is permitted under the statute and final rule. In response to commenters requesting clarification about whether eligibility for Medicaid coverage that is limited to emergency services counts as minimum essential coverage for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, this determination is subject to other rulemaking. We note, however, that individuals who are not lawfully present, are not eligible for enrollment in a QHP, let alone for enrollment in a QHP that is supported by advance payments and cost-sharing reductions. We also note that immigration status is not a factor for emergency Medicaid eligibility. In this final rule, we also revise §155.305(c) to streamline references to Medicaid citizenship and immigration status and residency eligibility standards, and align with the Medicaid MAGI-based assessment described under 42 CFR 435.911(c)(1). Lastly, regarding child-only plans, we note that the Exchange will inform an applicant of all of the QHPs for which he or she is eligible, including any child-only plans.

Comment: We received a range of comments related to performance measurement and oversight tools related to eligibility and enrollment. One commenter recommended a modification of Federal audit tools to ensure that States are evaluated based on the number of eligible people they correctly enroll for coverage. Some commenters recommended that QHP issuers should not be held responsible for any errors that the Exchange may make in the eligibility determination process, while some commenters sought clarification of an Exchange's liability for inaccurate eligibility determinations. Other commenters requested State flexibility

when operational challenges impede a seamless eligibility and enrollment process (including, for example, transitioning enrollees from one insurance affordability program to another).

Response: We plan to regulate in the future on oversight tools and performance measurements in future rulemaking and guidance. We will consider commenters' recommendations regarding oversight tools and performance measurement as we develop future guidance on this topic.

Comment: Several commenters strongly supported the Exchange sharing common eligibility standards with Medicaid, CHIP, and the BHP, and determining eligibility for the BHP. Several commenters suggested that the Exchange should conduct eligibility determinations for other programs that are not related to health insurance coverage, such as the Supplemental Nutrition Assistance Program and the National School Lunch Program. Other commenters stated that individuals who are served by those programs should also be enrolled in the appropriate health care program if they are not already enrolled. At least one commenter recommended that those applying for unemployment insurance also be directed towards health benefits for which they might be eligible.

Response: In the final rule, we do not require the level of integration between the Exchange and other human services programs that some commenters recommended. This would not preclude a State from leveraging the technology platform and supporting infrastructure for insurance affordability programs for other health and human services programs in the future, provided that privacy and security standards (and applicable cost allocation rules) are met, particularly regarding the use and disclosure of information provided to the Exchange by applicants and Federal agencies. To this end, on August 10, 2011 and January 23, 2012, CMS, the Administration for Children and Families (ACF), and the Food and Nutrition Service (FNS)

issued joint letters providing guidance on the limited exception to cost allocation guidelines which allows Federally-funded human services programs to benefit from Medicaid, CHIP, and Exchange technology investments.

Comment: We received a number of comments related to eligibility standards for advance payments of the premium tax credit, in particular regarding compliance with the filing requirement described in proposed §155.305(f)(4). Some commenters recommended that the final rule clarify that if a tax filer is determined eligible for advance payments of the premium tax credit but opts not to take advance payments, his or her ability to file for the credit at the end of the tax year is not affected; commenters also asked whether such a scenario would adversely affect his or her eligibility for cost-sharing reductions. One commenter requested clarification regarding the length of time for which a taxpayer would be deemed ineligible for advance payment of premium tax credit following a failure to file a tax return. Some commenters suggested States should have the flexibility to discontinue eligibility for advance payments of the premium tax credit and Medicaid if Federal tax filings are not current.

Response: We clarify that when a tax filer is determined eligible for advance payments of the premium tax credit but opts to not have advance payments made on his or her behalf, the tax filer may still claim the premium tax credit on his or her tax return; further, such action does not adversely affect his or her eligibility for cost-sharing reductions. Regarding §155.305(f)(4), we note that the language of the proposed rule, which we maintain in the final rule, specifies that the Exchange may not determine a tax filer eligible for advance payments if advance payments of the premium tax credit were made on behalf of the tax filer, or either spouse if the tax filer is a married couple, for a year for which tax data would be utilized for verification of household income and family size, and the tax filer or his or her spouse did not comply with the

requirement to file an income tax return for that year as required by 26 USC 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit for that period.

We also note that a tax filer faced with this bar to eligibility may be able to regain eligibility by filing a tax return and reconciling the advance payments of the premium tax credit. Lastly, we do not have authority to discontinue Medicaid eligibility based on a failure to file a tax return. In the final rule, we also make a correction to the eligibility criteria for advance payments of the premium tax credit at §155.305(f)(1)(ii) to align with the statutory requirement in section 36B(c)(1)(A) of the Code; the Exchange must generally determine that the tax filer is expected to have a household income of greater than or equal to 100 percent of the FPL.

Comment: We received several comments requesting clarification as to how eligibility will be determined for specific household composition scenarios. One comment, for example, asked for clarification regarding situations in States that recognize same-sex marriages or civil unions.

Response: In §155.305(f) in this final rule, we use a number of cross-references to section 36B of the Code which governs the premium tax credit; these rules are the same rules that are used to determine eligibility for advance payments of the premium tax credit. Consequently, we refer commenters to those rules for details regarding family and family size. Similarly, in §155.305(c) and (d), we use a number of cross-references to 42 CFR parts 435 and 457, which contain the Medicaid and CHIP rules for household composition; we refer commenters to those rules for details regarding these provisions.

Comment: We received a comment asking that we address the issue of deeming a sponsor's income to non-citizen applicants for Federal means tested public benefits; specifically,

the commenter asked whether that policy is applicable to calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions. The same commenter suggested that for applicants who are determined ineligible for Medicaid as a result of accounting for sponsor income and whose annual household income is below 100 percent FPL, we should apply the special rule described in §155.305(f)(2) that would allow such applicants to be determined eligible for advance payments of the premium tax credits.

Response: We intend to work closely with Treasury to address the applicability of sponsor deeming in the calculation of annual household income for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions through future rulemaking or guidance. Such rulemaking or guidance will also address the relationship between sponsor deeming and the special rule described in §155.305(f)(2).

Comment: Several commenters expressed concern about the affordability of coverage for low-income individuals, notably lawfully present immigrants who are eligible for advance payments of the premium tax credit but ineligible for Medicaid. Some commenters requested clarification that lawfully present non-citizens with incomes below 100 percent FPL could be determined eligible for cost-sharing reductions in the 100 to 150 percent FPL eligibility category.

Response: In response to comments received regarding lawfully present non-citizens with incomes below 100 percent FPL and eligibility for cost-sharing reductions, we are clarifying in §155.305(g)(2)(i) of the final rule that an individual who is eligible for advance payments of the premium tax credit under §155.305(f)(2) (non-citizens who are lawfully present and are ineligible for Medicaid) fall within the 100 to 150 percent FPL eligibility category for purposes of determining eligibility for cost-sharing reductions. We also correct §155.305(f)(1)(i) to

provide that an applicant who expects to have a household income of greater than or equal to 100 percent FPL may be determined eligible for advance payments of the premium tax credit; this is a technical correction to comply with section 36B(c)(1)(A) of the Code.

Comment: Several commenters suggested we clarify the relationship between advance payments of the premium tax credit and other forms of coverage, such as CHIP or Medicare, for determining eligibility as well as for the calculation of the premium tax credit.

Response: We note that comments of this nature are outside the scope of this rule and are within the jurisdiction of the Secretary of the Treasury.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.305 of the proposed rule, with several modifications: we added language throughout §155.305(a)(3) of the final rule to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards. In addition, in §155.305(a)(3)(i)(B), we include in the final rule that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not currently employed). We have also restructured paragraph (a)(3)(i) and (ii) for clarity, and have added specific references to the Medicaid final rule. In paragraph (c)(1), we also added a standard that 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 (that is, citizenship or immigration status, residency, etc.), as certified by the Medicaid agency at 435.1200(b)(2), and added a cross-reference to 42 CFR 435.603(d) for household income, in addition to the other criteria described under this paragraph. In paragraph (d), we added a cross-reference to 42 CFR 435.603(d) for household income.

In paragraph (f)(1)(i), we have changed "at least 100 percent" to "greater than or equal to 100 percent" to align with statutory language. In paragraph (f)(1)(ii)(B), we codified the exception for coverage in the individual market. In paragraph (f)(4), we have added, "or either spouse if the tax filer is a married couple," and clarified that applicable Treasury provisions requires a tax filer on whose behalf advance payments are made to both file an income tax return, and as a part of that return, to reconcile the advance payments made.

We have combined and restructured paragraphs (g) and (h) of the proposed rule into paragraphs (g)(1) and (g)(2) of the final rule. In paragraph (g)(2)(i) we have added a provision to implement section 1402(b) of the Affordable Care Act, which provides a special rule for non-citizens who are lawfully present; this revision clarifies that individuals who are expected to have a household income of less than 100 percent of the FPL for the benefit year for which coverage is requested and who are also eligible for advance payments of the premium tax credit under paragraph (f)(2) are eligible for cost-sharing reductions.

In paragraph (g)(3), we have added language implementing section 1402 of the Affordable Care Act, which provides cost-sharing reductions at a policy level, in situations where multiple tax households are covered by a single policy. In this paragraph, we specify a hierarchy of available cost-sharing provisions, and explain that when multiple tax households are covered on a single policy, the Exchange will apply only the first category of cost-sharing reductions listed in this paragraph. The categories are listed such that the lowest level of cost-sharing reductions will be provided to the combined households. We note that the tax households are always free to purchase separate policies, and in doing so, receive the benefit of all cost-sharing provisions for which they are eligible.

Lastly, in paragraph (g)(4) we added language to clarify that household income for the

purposes of eligibility for cost-sharing reductions is defined in accordance with section 36B(d)(2) of the Code, which is the same definition used for advance payments of the premium tax credit. We also clarified that the time period for measuring income for cost-sharing reductions is the same as for advance payments of the premium tax credit.

We also made technical changes to the final rule. In §155.305(c), we changed the reference to 42 CFR 435.1200(c)(1) to 42 CFR 435.1200(b)(2), and throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

d. Eligibility determination process (§155.310)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (e) of this section as an interim final provision, and we are seeking comments on it.

In §155.310, we proposed the process by which the Exchange will determine an individual's eligibility for enrollment in a QHP through the Exchange and for insurance affordability programs. Specifically, we proposed that the Exchange must accept applications from individuals in the form and manner described in §155.405, and included standards around the collection of information from non-applicants. We also proposed that the Exchange permit an individual to decline an eligibility determination for insurance affordability programs. In addition, we proposed that the Exchange accept an application and make an eligibility determination for an applicant seeking an eligibility determination at any point in time during a benefit year. After the Exchange has collected and verified all necessary data, we proposed that the Exchange conduct an eligibility determination in accordance with the standards described in §155.305 of this part.

We also proposed that the Exchange allow an applicant who is determined eligible for advance payments of the premium tax credit to accept less than the expected annual amount of advance payments authorized. We clarified that the Exchange may provide advance payments on behalf of a tax filer only if the tax filer first attests that he or she will meet the tax-related provisions discussed in the definition of tax filer, including that 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 tax family.

We also proposed that if the Exchange determines an applicant is eligible for Medicaid or CHIP, the Exchange will notify the State Medicaid or CHIP agency and transmit relevant information, including information from the application and the results of verifications, to the relevant agency promptly and without undue delay. We also proposed that effective dates for enrollment in a QHP through the Exchange, advance payments of the premium tax credit and cost-sharing reductions be implemented in accordance with the dates specified in §155.410(c) and (f) and §155.420(b).

We proposed that the Exchange provide an applicant with a timely, written notice of his or her eligibility determination, including the applicant's eligibility for insurance affordability programs, as appropriate. We also proposed that when the Exchange determines an applicant is eligible to receive advance payments of the premium tax credit or cost-sharing reductions based, in part, on a finding that the applicant's employer does not provide minimum essential coverage, provides coverage that is not affordable, or provides coverage that does not meet the minimum value standard, the Exchange must notify the employer and identify the employee.

Finally, we proposed rules regarding the duration of an eligibility determination for an applicant who is determined eligible for enrollment in a QHP but does not select a QHP within

his or her enrollment period in accordance with subpart E of this part. We solicited comments on whether a new determination should be conducted after a specific period of time has passed and whether the application process should begin anew in some or all situations.

Comment: We received a few comments recommending the adoption of a timeliness standard within which the Exchange would need to complete an eligibility determination. Most of these commenters recommended requiring that the Exchange adhere to the Medicaid timeliness standard as outlined in 42 CFR 435.911(a)(2), which provides that the Medicaid agency must establish a standard for determining an individual's eligibility and informing the individuals of his or her eligibility determination that does not exceed 45 days.

Response: We recognize that there is a need for a timeliness standard for Exchange eligibility determinations. We add paragraph (e) which states that the Exchange must conduct an eligibility determination promptly and without undue delay. We also include that 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. We intend to further interpret this timeliness standard in future guidance in coordination with standards established for the Medicaid and CHIP programs.

We note that we think it is reasonable that the majority of eligibility determinations will be completed in a very short period of time and encourage the Exchange to continuously monitor and identify ways to shorten the time it takes to process an application and notify an applicant of his or her eligibility determination. We plan to work closely with States to establish a more

detailed understanding of the timing needed for an eligibility determination as well as how the length of time needed can be reduced, and will provide future guidance on timeliness standards.

Comment: We received a substantial number of comments in support of our proposed policy, as described in §155.310(a)(2), that the Exchange may not require an individual who is not seeking coverage for himself or herself to provide a SSN except as provided in proposed §155.305(f)(6) (when he or she is the tax filer and the application filer attests that the tax filer has a SSN and has filed a tax return for the year for which the tax data would be utilized for verification of household and family size). While the majority of commenters supported the policy on the collection of SSNs, as proposed in §155.310(a)(2) and §155.305(f)(6), a few commenters suggested adding language to reinforce the applicability of guidance on the collection of SSNs issued on September 21, 2000 by CMS (then HCFA), the Administration of Children and Families, and the Food and Nutrition Service (the 'Tri-Agency guidance'); others asked that we cross-reference the companion provision in the Medicaid proposed regulation (42 CFR 435.907(e)(1)).

Response: First, in new §155.310(a)(3)(i), we have clarified that the Exchange must collect a SSN from an applicant who has a SSN. We have also moved the proposed provision in §155.310(a)(2) to §155.310(a)(3)(ii). We clarify that this provision only provides that the Exchange must collect SSNs from a non-applicant if he or she is the tax filer, has a SSN, and has filed a tax return for the year for which tax data would be utilized. We believe this provision is necessary given the standards for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, as described in sections 1402(f)(3), 1411(b)(3) and 1412(b) of the Affordable Care Act, which provide that the most recent tax data available be the basis for determining eligibility for these benefits to the extent such tax data is available.

In addition, we note that section 36B(d)(2)(A)(ii)(II) of the Code specifies that household income for purposes of premium tax credits includes the MAGI of any individuals who have a filing requirement. As previously noted, a SSN must be used to obtain tax data from the IRS, and the IRS will not provide the tax data of a dependent who had a filing requirement without the dependent's SSN. As noted above, while the Exchange will require an individual who is seeking coverage for himself or herself who has a SSN to provide it, the Exchange will only require an individual who is not seeking coverage for himself or herself to provide a SSN if he or she is a tax filer who meets the standard described in paragraph (f)(6). That is, in the limited number of cases in which a dependent is not seeking coverage for himself or herself, the Exchange will not require such a dependent to provide his or her SSN, although the dependent may provide it on a voluntary basis. However, we believe that §155.305(f)(6), as proposed, is permissible under section 1412, given that a) whether a dependent has a filing requirement may change frequently, resulting in a change in circumstances that allows the Exchange to use an alternate verification process; and b) we believe that it will be challenging for an applicant to determine whether a dependent was or will be required to file (versus a voluntary filing). Further, we do not believe that it is appropriate to add a provision to require the Exchange to collect the SSN for every dependent who is not seeking coverage for himself or herself, regardless of whether he or she had a filing requirement, because this would go beyond what is needed to obtain tax data for those who had a requirement to file. As such, we maintain this provision in the final rule. To the extent that a dependent who is not seeking coverage for himself or herself has income that needs to be considered for purposes of determining eligibility for advance payments of the premium tax credit and cost-sharing reductions, the Exchange will verify it through an alternate verification process.

We believe that these provisions also comply with the statutory standards contained in section 1411(g)(1) of the Affordable Care Act, which specifies that the Exchange must not require an applicant to provide information beyond what is necessary to support the eligibility and enrollment process. Given the statutory standards, we believe these are the appropriate application of the Tri-Agency guidance. We intend to continue to review these issues in the context of all insurance affordability programs and to develop a single, streamlined application that accommodates these policy and eligibility differences.

In addition, we have added §155.315(b), which clarifies that in accordance with section 1411 of the Affordable Care Act, the Exchange will transmit SSNs to HHS for validation with SSA. This is separate from the provision regarding citizenship verification, and only serves to ensure that SSNs provided to the Exchange can be used for subsequent transactions, including for verification of family size and household income with IRS. We clarify that in accordance with section 1411(e)(3) of the Affordable Care Act, which governs inconsistencies regarding SSNs, to the extent that the Exchange is unable to validate a SSN, the Exchange will follow the inconsistency procedures specified in §155.315(f).

Comment: We received a number of comments in support of our proposed policy to allow applicants to opt out of an eligibility determination for insurance affordability programs but to not allow applicants to choose among a subset of insurance affordability programs in proposed §155.310(b). Only one commenter did not support the provision to allow individuals to opt out of screening for insurance affordability programs, citing that it is more important to provide a uniform eligibility determination for all applicants to increase the likelihood that individuals have access to affordable coverage options. One commenter also suggested that the final rule provide certain exceptions to the provision barring individuals from selecting among

insurance affordability programs.

Response: We believe it is important to preserve the option for an applicant to bypass the examination of his or her household income and other information that may result in a lengthier eligibility process, and allow him or her to enroll directly in a QHP without financial assistance if he or she so chooses. Therefore, in the final rule, we are maintaining the provision in §155.310(b) with some clarification; the Exchange must permit an applicant to request only an eligibility determination for enrollment in a QHP through the Exchange, but that the Exchange may not permit an applicant to request an eligibility determination for less than all insurance affordability programs. We expect that an Exchange could implement this provision by allowing an applicant to opt-out of an eligibility determination for all insurance affordability programs.

We also maintain that an applicant may not choose between insurance affordability programs since section 36B(c)(2)(B) of the Code specifies that a tax filer is ineligible for advance payments of the premium tax credit for any applicant who is eligible for other minimum essential coverage.

Comment: A number of commenters, particularly consumer groups, noted support for the provision in proposed §155.310(d)(2), which would allow 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; however, the majority of these commenters recommended that HHS complement this provision with a standard that the Exchange must provide detailed consumer education and tools regarding the premium tax credit and reconciliation. We also received a number of comments which raised concerns that individuals may not fully understand the responsibilities associated with receiving advance payments of the premium tax credit; such commenters recommended that HHS provide more detail concerning what information will be provided to consumers about

reconciliation.

Response: We amended the final rule in §155.310(d)(2)(ii) to state that the Exchange may authorize advance payments of the premium tax credit on behalf of a tax filer only if the Exchange obtains certain attestations regarding advance payments of the premium tax credit from a tax filer. We intend to provide further guidance regarding the additional attestations that may be asked of individuals, which may include an attestation from a tax filer acknowledging that he or she understands the potential impact of reconciliation.

Comment: We received a number of comments regarding the standards for Exchanges to notify the State Medicaid or CHIP agency upon determining an applicant eligible for Medicaid or CHIP and transmit relevant information promptly and without undue delay described in proposed §155.310(d)(3). Commenters recommended that HHS provide a timeliness standard that is more specific than "promptly and without undue delay," and suggested adding language to provide the Exchange must transmit the relevant information "within no more than 24 hours."

A few commenters also recommended aligning with Medicaid language to clarify that "relevant information" transmitted to Medicaid or CHIP agencies include "the electronic account containing the finding of Medicaid or CHIP eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such a finding."

Response: We considered the recommendation to adopt a specific time standard for the transmittal of information between the Exchange and State Medicaid or CHIP agencies; however, we believe that the timeliness standard in the regulation text at paragraph (e) provides the necessary flexibility to accommodate technological advances. We anticipate that we will interpret and clarify this standard in guidance. Furthermore, this standard is aligned with the Medicaid standard described in 42 CFR 435.911(c)(1); CMS also plans to issue guidance to

clarify this standard.

We also considered comments asking HHS to specify the meaning of "relevant information." We recognize that clarification is necessary, and in the final rule, replace the phrase "relevant information" in §155.310(d)(3), with "all information necessary to effectuate coverage in Medicaid or CHIP." Although this is not the identical language used in Medicaid regulations, we believe it is the appropriate standard to adequately address the concern raised by the commenter.

Comment: We received a variety of comments related to the notification of eligibility determination, described in proposed §155.310(g). Several commenters asked that we amend the language in this provision to provide that such a notice must be "written," as we specified in the proposed rule governing general notice standards in §155.230(a). One commenter suggested adding language to allow applicants or enrollees to choose to have notices sent to other parties, such as application assisters or authorized representatives; another recommended adding a notice to individuals when an application is incomplete.

Response: Because paragraph §155.230(a) of the proposed rule specifies that notices issued by the Exchange must be "written," this general notice standard would apply to the notification of eligibility determination, which we clarify in §155.310(g) in this final rule. We will further address notices and the roles of application assisters and authorized representatives in future rulemaking and guidance.

Comment: We received a large number of comments on proposed §155.310(g) regarding the content and scope of employer notices of an employee's eligibility for advance payments of the premium tax credit and cost-sharing reductions. These commenters suggested that HHS limit employer notices to a subset of employers to provide greater privacy protections for consumers.

Most commenters stated that the employer should be notified of an employee's receipt of advanced payment of the premium tax credit or cost-sharing reductions only if this determination might trigger an employer responsibility payment. Some commenters asserted that the appropriate trigger for an employer to receive notification is if the employer has 50 or more full time equivalent employees and the employer has full-time employees that receive advanced payment of the premium tax credit or cost-sharing reductions through the Exchange. One commenter said that only employers that offer unaffordable coverage should receive a notification and employers that offer no coverage should not receive any employee information.

Response: While we recognize that the employer responsibility provisions of section 4980H of the Code apply only to employers with 50 or more full-time equivalent employees, section 1411(e)(4)(B)(iii) of the Affordable Care Act imposes the obligation to provide the notice regardless of the size of the employer. Therefore, we are not limiting the scope of the notice standard in this final rule to a subset of employers. We anticipate that HHS may provide additional guidance regarding how the content of the notice can be structured so as to minimize potential employer confusion associated with whether a determination will have implications under section 4980H of the Code.

Further, we are aware that employer contact information may not always be available, because a person fails to provide it, or provides incorrect information, or that person changed employers, or a host of other reasons. We will work with Exchanges and employers on this to develop a solution for situations in which the Exchange does not have a seamless way to reach the correct employer for the purposes of delivering the notice.

Comment: Other commenters raised additional privacy concerns regarding the content of notices sent to employers under proposed §155.310(g). Several commenters suggested that the

Exchange provide the employer with the minimum amount information necessary to evaluate liability for the employer responsibility payment. One commenter suggested that the Exchange should only transmit information necessary under law—the employee name and taxpayer identification number. This commenter stressed that the regulation should specify that the taxpayer identification number (TIN) should be used, and not the SSN, in accordance with section 1311(d)(4)(I)) of the Affordable Care Act. One commenter suggested that even the employee name should not be disclosed. Finally, a few commenters noted that HHS should be sensitive to the fact that some employees do not want their employers to know their household income.

Response: For the purposes of the employer notice under section 1411(e)(4)(B)(iii) of the Affordable Care Act, we believe that only the minimum necessary personally identifiable information should be released to an employer. The Affordable Care Act provides that the Exchange must notify an employer that his or her employee has been determined eligible for advance payments of the premium tax credit and that the employer may appeal such eligibility determination. The proposed rule provided only that the notice identify the employee. However, based on sections 1411(e)(4)(B)(iii), 1411(e)(4)(C), and 1411(f)(2)(B) of the Affordable Care Act, our final regulation provides that if an enrollee is eligible for a premium tax credit or cost-sharing reductions because that enrollee's employer does not provide minimum essential coverage through an eligible employer-sponsored plan, or that the employer provides coverage but it is not affordable or does not meet minimum value, the Exchange must notify the employer, identifying the employee, relating the opportunity to appeal, indicating that the employee has been determined eligible for advance payments of the premium tax credit, and indicating that the employer may be liable for a shared responsibility payment under section 4980H of the Code if

the employer has 50 or more full-time workers. We note that we do not expect the Exchange to relay to the employer the exact reason for which the applicant was determined eligible, or to provide any tax return information to the employer. Rather, the notice should indicate the list (above) of potential reasons for the determination. We have amended the final rule, redesignating proposed section (g) as section (h) and adding sections (h)(2) and (h)(3) to §155.310 to clarify these standards.

The notice will not disclose an enrollee's household income or any other taxpayer information, except the enrollee's name or other personal identifier. We anticipate that additional guidance regarding the content of the notification will be released in the future.

Comment: One commenter expressed concern about potential HIPAA violations that may occur if an applicant provides the wrong employer contact information, and an incorrect employer receives the notification, with respect to the notices sent in accordance with proposed §155.310(g).

Response: To the extent the Exchange is not a HIPAA covered entity or business associate, the Exchange would be subject only to the privacy and security standards of 155.260. If a State has determined that its Exchange is a HIPAA covered entity or business associate, to the extent the Exchange was merely acting on incorrect information provided to the Exchange by an applicant, there would be no HIPAA violation. In addition, we do not expect that the notice will result in a violation of applicable privacy and security standards in this section. We acknowledge that the notices outlined under this section will contain personally identifiable information, such as the name of enrollees. However, we think any inadvertent disclosure would be mitigated by the fact that only minimal information about the individual will be included in the employer notice; thus, we do not believe that this standard poses a substantial threat to

individual privacy. In addition, we plan to disseminate guidance to Exchanges on practices designed to minimize the instances of individuals or entities other than the enrollee's actual employer receiving the notice.

Comment: A number of commenters asked that Exchanges inform employers that retaliation based on the notices sent in accordance with §155.310(g) is prohibited and that evidence of retaliation could subject the employer to a penalty.

Response: We note that section 1558 of the Affordable Care Act, which amends the Fair Labor Standards Act and is within the jurisdiction of the Department of Labor, includes a prohibition on an employer discharging or discriminating against an employee because the employee has received a premium tax credit or cost-sharing reductions. Because of this statutory provision, we do not believe additional standards are necessary in this final rule.

Comment: One commenter suggested that IRS, and not HHS, effectuate the notice described in §155.310(h) because (1) IRS has information about employers subject to free rider assessments, and (2) IRS maintains a database of employer contacts for the transmission of sensitive personal information. Another commenter suggested that reporting to employers should be consolidated and centralized into a Federal process, with information provided on a monthly or quarterly basis.

Response: Section 1411(e)(4)(B)(iii) provides that this notice must be provided to employers by Exchanges in connection with certain eligibility determinations. It is not within the discretion of the Secretary to shift responsibility for provision of this notice to the IRS. We do support reducing reporting burden by consolidating and streamlining reporting, if feasible. In addition, we plan to issue guidance to help Exchanges develop an operational strategy for reporting.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.310 of the proposed rule, with a few modifications. In paragraph (b), we clarified that the choice of an applicant is whether to allow the Exchange to determine his or her eligibility for insurance affordability programs. In paragraph (d)(2)(ii), we added language specifying that attestations from the tax filer will be attestations regarding advance payments of the premium tax credits. In paragraph (d)(3), we removed the reference to "relevant" information and further clarified that the Exchange must transmit all information from the records of the Exchange promptly and without undue delay to such agency that is necessary for the State Medicaid or CHIP agency to provide the applicant with coverage. In paragraph (e), we adopted a provision which provides that the Exchange must conduct eligibility determinations promptly and without undue delay.

In paragraph (f), we clarified in the header that the effective dates outlined are effective dates for eligibility, and not for coverage. Consistent with changes we discuss in §155.420, we also added language in paragraphs (f)(1) and (f)(2) to differentiate between effective dates for initial eligibility determinations, which will be implemented in accordance with §155.410(c) and (f) and §155.420(b), as applicable, and effective dates for redeterminations, which will be implemented in accordance with the dates specified in §155.330(f) and 155.335(i), as applicable. In paragraph (g), we added language to specify that the notice of eligibility determination must be written, consistent with other notice standards. We redesignated proposed paragraph (g) as new paragraph (h). In new paragraph (h), we added three additional standards, in accordance with section 1411(e)(4) of the Affordable Care Act, for the content of the notice to employers. In addition to identifying the employee, the notice must indicate that the employee has been determined eligible for advance payments of the premium tax credit; 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 that the employer has the right to appeal the determination.

Also included in this final rule are several technical corrections from the proposed text. In paragraph (a)(1), we removed the reference to 45 CFR and changed the phrase to "specified in §155.405 of this chapter." In paragraph (b), we added the words "insurance affordability" before "programs" as a clarification.

e. Verification process related to eligibility for enrollment in a QHP (§155.315)

Based on comments and feedback to the proposed rule, we are revising the rule to include paragraph (g) of this section as an interim final provision, and we are seeking comments on it.

In §155.315, we proposed the general standard that the Exchange must verify or obtain information to determine that an applicant is eligible for enrollment in a QHP, unless a request for modification is granted in accordance with proposed paragraph (f) of this section.

To verify whether an applicant for coverage through the Exchange is a citizen, national, or otherwise lawfully present individual in accordance with section 1312(f)(3) of the Affordable Care Act, we proposed to codify the role of the Secretary (through HHS) as an intermediary between the Exchange and other Federal officials, specifically the Social Security Administration and the Department of Homeland Security. In the case of an inconsistency related to citizenship, status as a national, or lawful presence, we proposed that the time period for the resolution is 90 days from the date on which the notice of inconsistency is received. We also clarified that the date on which the notice is received means 5 days after the date on the notice, unless the applicant shows that he or she did not receive the notice within the 5 day period.

We also proposed that the Exchange verify an applicant's residency by accepting an applicant's attestation without further verification or following the procedures of the State

Medicaid or CHIP agency, if such agency examines electronic data sources for all applicants. We also proposed that the Exchange may examine data sources regarding residency to the extent that information provided by an applicant regarding residency is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. In addition, we proposed that a document that provides evidence of immigration status may not be used alone to determine State residency. We also proposed that the Exchange verify an applicant's attestation that he or she is not incarcerated. We solicited comment as to what electronic data sources are available and should be authorized by HHS for Exchange purposes, including whether access to such data sources should be provided as a Federally-managed service like citizenship and immigration status information from SSA and DHS.

Further, we proposed that when an individual attests to information and such attestation is inconsistent with other data in the records of the Exchange, the Exchange must make a reasonable effort to identify and resolve the issues. If the Exchange is unable to resolve the inconsistencies, we proposed that the Exchange notify the applicant of the inconsistency. After providing this notice, we proposed that the Exchange provide 90 days from the date on which the notice is sent for the applicant to resolve the issues, either with the Exchange or with the agency or office that maintains the data source that is inconsistent with the attestation. We also proposed that the period during which an applicant may resolve the inconsistency may be extended by the Exchange if the applicant can provide evidence that a good faith effort has been made to obtain additional documentation.

We further proposed that the Exchange allow an individual who is otherwise eligible for enrollment in a QHP, advance payments of the premium tax credit or cost-sharing reductions to receive such coverage and financial assistance during the resolution period, provided that the tax

filer attests to the Exchange that he or she understands that any advance payments of the premium tax credit received during the resolution period are subject to reconciliation. We also proposed that if after the conclusion of the resolution period, the Exchange is unable to verify the applicant's attestation, the Exchange must determine the applicant's eligibility based on the information available from the data sources specified in this subpart and notify the applicant of such determination. We clarified that the Exchange must make effective this eligibility determination no earlier than 10 days after and no later than 30 days after the date on which such notice is sent.

Finally, we also proposed that HHS may approve an Exchange Blueprint to change the methods used to collect and verify information, within certain standards. We also proposed that the Exchange must not require an applicant to provide information beyond the minimum necessary to support eligibility and enrollment processes.

Comment: We received a few comments asking that we establish standards for the collection, use and safeguarding of data used to verify applicant information, as described throughout proposed §155.315. We received a few comments suggesting that we incorporate specific safeguards and protections for information used in the verification of citizenship and immigration status, proposed in §155.315(b). Commenters suggested including language stating that information related to the verification of citizenship and immigration status be used only for purpose of verifying eligibility for enrollment in a QHP and that pending such verification, coverage should not be delayed, denied, reduced or terminated.

Response: We address the privacy and security of information and the specific standards and protocols for the transmission of data in §155.260 and §155.270 of this final rule and note that these provisions apply to the transactions described throughout subpart D, including

§155.315. Language in §155.260 provides that information must provided to or obtained by the Exchange for the purposes of determining eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions, under sections 1411(b) through(e) of the Affordable Care Act, or exemptions from the individual responsibility provisions in section 5000A of the Code, may only be used to carry out those minimum functions of the Exchange described in §155.200; we believe this language addresses these concerns and establishes appropriate safeguards.

Regarding comments asking that coverage not be delayed, denied, reduced or terminated, pending verification of citizenship and immigration status, we addressed these concerns in §155.315(f), which allows an applicant to enroll in coverage with financial assistance pending such verification. We also amend §155.315(c) in order to be consistent throughout this subpart and clarify that an applicant and not an application filer receives the notice of inconsistency.

Comment: A number of comments addressed the process for resolving inconsistencies between applicant information and data obtained by the Exchange, as proposed in §155.315(e). Commenters requested that we provide details on the types of documentation that the Exchange may use to verify applicant information; specifically, commenters asked for details on documents that the Exchange will be permitted to use in verifying citizenship and immigration status. Others commenters asked that we clarify the ways in which individuals will be able to submit documentation to the Exchange when attempting to resolve such inconsistencies. Furthermore, in response to the Medicaid eligibility proposed rule, HHS received a number of comments requesting adoption of an exception for agencies administering insurance affordability programs to accept attestations alone from certain applicants, who are part of at-risk populations and who may not have access to necessary documentation to resolve inconsistencies.

Response: While we acknowledge commenters' requests for details regarding documentation used during the inconsistency process, we believe that this level of specificity is most appropriate for guidance. Therefore, we maintain that the applicant may "present satisfactory evidence" in §155.315(f)(2)(ii) of the final rule. We intend to issue future guidance with details on documents which may be used to support verification, in coordination with Medicaid and CHIP and in accordance with the statutory standard for the Exchange to follow the procedures specified in section 1902(ee) of the Act.

We accept commenters' suggestions that we specify the ways in which an applicant will be able to submit documentation to the Exchange; accordingly, we adopt language in the final rule at §155.315(f)(2)(ii) that the Exchange must provide the applicant with the opportunity to present satisfactory documentary evidence via the channels available for the submission of an application, as described in §155.405, except for by telephone.

We also proposed a provision in §155.315(g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available. We proposed this language to account for situations which documentation cannot be obtained, and to achieve consistency with the Medicaid program; examples of individuals for whom this provision may apply include homeless individuals, victims of domestic violence or natural disasters, and sporadic earners. We believe that adding this provision is permissible within the Secretary's statutory authority to change verification methods as provided under sections 1411(c)(4) and 1321(a)(1) of the Affordable Care Act. We note also that if at the conclusion of the 90 day period, the Exchange is unable to verify the applicant's attestation and the data from the data sources specified in §155.315 are unavailable, the Exchange must notify that applicant that the Exchange finds the applicant ineligible for the eligibility standard in question. In

§155.320(c)(3)(vi)(F), we also describe the procedures for the Exchange to discontinue advance payments and cost-sharing reductions in the event that the applicant's attestation is not verified by the conclusion of the 90 day period.

We also make several changes throughout verification provisions of the final rule at §155.315 and §155.320 where information is found by the Exchange to be not reasonably compatible with an applicant's attestation and where the inconsistency process is triggered; we change the language in a number of places to state that the Exchange "must," rather than "may," examine electronic data sources or supporting documentation, when applicable. The proposed rule did not consistently require that the Exchange examine other data sources or documentary evidence for all verification processes.

Comment: We received several comments regarding our use throughout §155.315 of the term "reasonably compatible." Many commenters asked that we define the term and provided a number of suggested definitions; one common approach to clarifying the term was to provide the Exchange must only consider material differences between an attestation and available electronic data as not reasonably compatible.

Response: We believe that the common approach suggested by commenters is a sensible one, and in §155.300(d) of this final rule, provide that the Exchange must consider information to be reasonably compatible with an applicant's attestation if the difference or discrepancy does not have an impact on the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost-sharing reductions. This provision would provide, for example, that if an individual attested to one address within an Exchange service area, but Exchange-obtained data demonstrated a different address within the same Exchange service area, he or she must be considered to meet the residency eligibility standard. We note that while we

provide this clarification in the final rule, Exchanges may still exercise flexibility in defining what is considered reasonably compatible. We expect that definitions will vary depending on the types of information subject to verification, and that States will use this flexibility to enhance the eligibility process. We intend to provide future guidance on this issue. We also clarify that to the extent that income information provided by an application filer and income information obtained through electronic data sources both indicate that the applicant is eligible for Medicaid or CHIP, such information must be considered reasonably compatible; this provision aligns with the provision of the Medicaid eligibility final rule at 42 CFR 435.952(c)(1). We also clarify that this rule does not mean that an applicant's attestation regarding annual household income must be identical to that of the tax return information in order to be considered reasonably compatible. The standard for household income is discussed in more detail in §155.320.

Comment: We received a few comments which asked that we explicitly state that an applicant has the ability to access and amend the data used to determine his or her eligibility.

Response: Section 155.330 of the proposed rule allowed an enrollee to report changes affecting his or her eligibility to the Exchange, which must then be verified by the Exchange. We maintain this provision in this final rule. We anticipate that the Exchange will make the information used in an eligibility determination available to the applicant and enrollee, including through a web-based self-service tool with appropriate safeguards. In addition, we direct the commenter to the final rule at §155.260(b)(3)(i), which provides the Exchange must incorporate a principle of individual access to personally identifiable information as part of the Exchange's privacy and security policies and procedures.

Comment: We received comments asking that we specify the content of the eligibility determination notice provided to applicants, which is described in proposed §155.315(e)(2)(i).

Commenters also suggested certain content standards for such a notice, including clear procedures for the inconsistency process.

Response: As noted in the notice of proposed rulemaking, we intend to provide content and timing standards for notices in future rulemaking and guidance. We have made a minor edit to the final rule at §155.315(f)(2)(i) to clarify that this notice is sent to the applicant by the Exchange.

Comment: We received a number of comments regarding the process to resolve inconsistencies, as described in proposed §155.315(b)(3) and (e). A few comments asked that the inconsistency periods described in proposed §155.315(b)(3) and (e) begin when the application is submitted, not when the notice of inconsistency is sent or received by the applicant. Other commenters asked that we align inconsistency periods for the Exchange with the inconsistency period described in section 1902(ee) of the Act.

Response: Section 1411(e)(3) of the Affordable Care Act states that for inconsistencies related to citizenship and immigration status, the Exchange must follow procedures described in section 1902(ee) of the Act. Section 1902(ee) provides that the applicant must be given a period of 90 days from the date of the receipt of the notice to present satisfactory documentation. Because such a receipt date is difficult to pinpoint, we have adopted language specifying that the date on which the notice is received is 5 days from the date the notice is sent, unless the applicant demonstrates that he or she did not receive the notice within the 5 day period. This standard is also utilized by the SSA. Alternatively, for inconsistencies not related to citizenship and immigration status, section 1411(e)(4)(A)(ii)(II) of the Affordable Care Act provides that the 90 day period must begin on the date on which the notice is sent to the applicant. Due to these statutory standards, we are unable to change the point at which the inconsistency period is

triggered, and unable to further align the provision in proposed §155.315(e) with the process described in section 1902(ee) of the Act. Therefore, we maintain the provisions in §155.315(c)(3) and (f) in the final rule.

We neglected to include the statutory language found in section 1411(e)(4)(A)(i) of the Affordable Care Act which provides that the Exchange must address "typographical or clerical errors" in order to address causes of inconsistencies, prior to accepting documentation or other evidence from the applicant; we adopt this language in the final rule at §155.315(f)(1).

Comment: We received a number of comments which expressed concern over the potential for increased liability for QHP issuers as applicants are provided coverage during the inconsistency period described in proposed §155.315(e). We also received comments suggesting that issuers should not be required to enroll, nor continue enrollment of, individuals for whom the Exchange is still verifying eligibility during the resolution period.

Response: The standard to determine eligibility based on the information on the application (that is, an individual's attestation) during the inconsistency period is specified in section 1411(e)(3) and (e)(4) of the Affordable Care Act. We note that this final rule does not prohibit QHPs from requiring premium payment prior to providing coverage. We also expect that the Exchange and an applicant's selected QHP issuer will provide notice to an applicant to ensure that the enrollee is aware of liability for premium payment.

Comment: One commenter suggested that the Exchange be given more flexibility to decrease the length of the inconsistency period.

Response: The period of time during which an applicant is permitted to provide documentation in order to resolve an inconsistency is specified in sections 1411(e)(3) and 1411(e)(4)(A)(ii)(II) of the Affordable Care Act; therefore, we maintain provisions

§155.315(c)(3) and (f)(2)(ii) the final rule.

Comment: A few commenters asked that we explicitly allow certain application assisters, Navigators, and application filers to help applicants navigate the inconsistency process, described in proposed §155.315(e).

Response: As described in §155.210, part of the duties of a Navigator will be to educate the consumer, facilitate enrollment, and assist with any part of the application process. We also anticipate that agents and brokers will provide such assistance. In addition, we expect that application assisters who are not Navigators, agents, or brokers will provide support for consumers during the application process, and we anticipate providing additional guidance regarding this role, including on appropriate privacy and security protections.

Comment: We received a number of comments on proposed §155.315(e)(3), in which we proposed that the Exchange may extend the inconsistency period if the applicant demonstrates a good faith effort to obtain the documentation. Commenters asked that the Exchange must provide such an extension

Response: We adopted the provision regarding the extension of the inconsistency period in order to align with Medicaid guidance, which provides States the flexibility to allow a good faith extension. Therefore, we are maintaining the proposed text in the final rule.

Comment: We received a comment asking that we include timeliness standards for processing inconsistencies.

Response: We adopt a timeliness standard of "promptly and without undue delay" for eligibility determinations made by the Exchange in the final rule at §155.310(e), but intend to provide future guidance about best practices for an Exchange to make the best use of the 90 day inconsistency period.

Comment: We received a number of comments on proposed §155.315(g), in which we proposed that the Exchange may not require the applicant to provide information beyond the minimum necessary to support the eligibility and enrollment process. Commenters asked us to define "minimum necessary"; others suggested that we include language describing how HHS will conduct oversight to ensure compliance with this provision.

Response: We acknowledge the importance of oversight to ensure compliance with the provision described in §155.315(g) of the proposed rule, which is finalized in §155.315(i), and intend to provide additional detail regarding oversight in future rulemaking and guidance. HHS will also consider this in the context of evaluating alternate applications developed by States, as described in §155.405(b), and will continue to work with States on the issue of information collection.

Comment: We received a number of comments related to the proposed process for verification of citizenship and immigration status, described in proposed §155.315(b). A few commenters found the process unclear, and asked for more information regarding the verification process for other individuals listed on the application, such as spouses and tax dependents.

We also received a number of comments related to the services that will be provided by a Federally–managed data services hub to support verification of citizenship and immigration status. Several comments recommended that we utilize the DHS Systematic Alien Verification for Entitlements (SAVE) system to verify immigration status. Comments on the proposed rule asked for information on the impact of services available through the Federally-managed data services hub on existing State agency connections with Federal data sources used for verification of citizenship and immigration status. Commenters recommended that Exchanges not use "E-verify" to verify immigration status and others asked that we provide details on the format of

data provided to the State agency or Exchange. We also received comments asking whether it would be legally permissible for the Exchange to transmit information to DHS, via HHS, when an individual has attested to being a citizen. Another commenter asked how the Exchange will know whether an individual has documentation at the point of application that can be verified through DHS, as described in the provision proposed at §155.315(b)(2).

Response: Section 1312(f)(3) of the Affordable Care Act, as codified in §155.305(a)(1) in this final rule, states that an individual may only enroll in a QHP through the Exchange if he or she is a citizen, national, or a non-citizen who is lawfully present, and is reasonably expected to be so for the entire period for which enrollment is sought. Because citizenship, status as a national, or lawful presence is an eligibility standard for any applicant seeking coverage through the Exchange for him or herself, the verification process described in §155.315(c) applies to each applicant, regardless of whether he or she is a tax filer or dependent.

While we do not specify a level of operational detail in the final rule that includes the specific services or data formats which will be used in supporting verification, we are working closely with our Federal partners to develop and provide details on the verification services provided by the Federally-managed data services hub; we expect to provide such details in guidance. However, we believe that the final rule supports the use of SAVE. We also note that we do not intend to use the E-verify service, as it is designed for employers to check the work authorization of employees, rather than to verify eligibility for benefits. Regarding existing State connections used in verification, we anticipate that Medicaid agencies, CHIP agencies, and Exchanges will leverage the Federally-managed data services hub for connections to SSA and DHS to support verification of citizenship and immigration status.

With regard to the Exchange transmitting information to DHS via HHS, when an

individual has attested to being a citizen, section 1411(c)(2) of the Affordable Care Act specifies that in such cases when an individual who attests that he or she is a citizen but for whom citizenship cannot be verified through SSA, the Secretary of HHS shall submit to DHS the applicant's information and other identifying information for verification of immigration status. Based on this statutory standard, we maintain §155.315(b)(2) in the final rule as §155.315(c)(2).

Lastly, we intend to work with DHS to provide Exchanges with the information needed to identify whether an applicant can likely be matched through DHS. DHS has existing verification relationships with many State Medicaid and CHIP agencies, as well as other Federal, State, and Local government entities, which means that many States will already be familiar with this information.

Comment: We received several comments recommending the inclusion of language in proposed §155.315(b) describing the verification process as to whether an applicant is "reasonably expected" to be lawfully present for the entire period for which enrollment is sought. The "reasonably expected" standard is part of the standard for determining whether an applicant is a citizen, national or non-citizen who is lawfully present, which is described in §155.305(a)(1). Commenters' specific recommendations for such a verification process varied. One requested that as long as an applicant's residency is verified, that he or she be considered reasonably expected to be lawfully present for the entire period for which enrollment is sought. Others suggested that self-attestation alone be used in verification.

Response: In the final rule, we address our interpretation of the term "reasonably expected" in §155.305. We intend to provide additional interpretation of this standard, including how it applies in specific scenarios, in future guidance.

Comment: We received a few comments asking that we specify in regulation that an

applicant is permitted to provide his or her A-number for verification of immigration status through the records of DHS.

Response: In §155.315(b), we proposed that for purposes of verifying citizenship and immigration status through the records of DHS, the Exchange must transmit information from the applicant's documentation and other identifying information to HHS. We intend the phrase "information from the applicant's documentation and other identifying information" to encompass information such as A-numbers; therefore, we maintain the provision in the final rule. This approach incorporates other types of identifying information (for example, I-94 numbers) that are used by DHS, as well as preserves the intent and applicable of this regulation if DHS changes its process in the future.

Comment: We received a number of comments regarding the connections between the Exchange and Federal data sources needed to support verification of applicant information. Comments expressed concern that each Exchange would need to develop separate data sharing arrangements and interfaces with Federal agencies maintaining information for use in verification. Comments responding to the proposed rule, which identified HHS as a conduit for information transmitted between the Exchange and Federal agencies, asked that we specifically refer to the Federally-managed data services hub, or electronic service, throughout §155.315, rather than refer to HHS as the entity through which data will be transmitted.

Response: Acknowledging comments to the RFC and specific direction from section 1411(c) of the Affordable Care Act, we proposed that HHS would be the entity through which information would be transmitted to and from Exchanges and Federal data sources to support the verification process. In the final rule, we maintain HHS' role in supporting verification. However, in order to remain flexible to the technology used to transmit such data, we do not

specifically mention in the final rule the "electronic service" or "data services hub". Instead, the final rule focuses on HHS' role as the entity which will facilitate the transfer of information, rather than how such information will be transferred. We anticipate that as technological advances are made, there may be changes in the procedures used by HHS to receive information from the Exchange and to communicate with other Federal agencies involved in the verification process.

Comment: We received a number of comments on the process for verification of residency, proposed in §155.315(c). A significant number of commenters asked that self-attestation of residency be accepted without further verification. A smaller number of commenters recommended always allowing the Exchange to verify residency through electronic data sources, not only when the State Medicaid or CHIP agency operating in the State of the Exchange opts to examine such data sources.

Response: We are redesignating proposed §155.315(c) as §155.315(d), and amending it to state that an Exchange may accept an attestation of residency from an applicant or examine electronic data sources which have been approved by HHS. This flexibility would allow an Exchange, should it choose, to align with the verification procedures of the State Medicaid or CHIP agency. Such alignment may facilitate integration across insurance affordability programs and result in a more streamlined process. We amend §155.315(d)(3), as well as equivalent provisions throughout this subpart, to specify that if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through other electronic data sources. The proposed rule was inconsistent, and used, "may," instead of, "must," in this paragraph and in several other areas. This change was made to create consistency throughout the subpart, and because the rationale for the reasonably

compatible concept, as described in the proposed rule, is that it is a threshold for when additional verification (for example, examining other electronic data sources) is necessary to complete the verification process. For example, in the event the Exchange accepts self-attestation without further verification, in accordance with paragraph (d)(1), and such attestation is found to be not reasonably compatible with other information provided by the individual or in the records of the Exchange, the Exchange would continue the verification process by examining available electronic data sources in order to verify the attestation. If the Exchange is still unable to complete the verification after examining information in electronic data sources, the Exchange would then follow procedures to resolve the inconsistency, in accordance with §155.315(f). As discussed in the proposed rule, examining data sources, when available, prior to moving through the inconsistency process will help minimize the need to request paper documentation from applicants, and the burden for Exchanges to process such documentation.

Comment: We received a few comments regarding the provision in proposed §155.315(c)(4) in which we propose that a document that provides evidence of immigration status may not be used alone to determine State residency. A commenter requested that we remove the word "alone" from this phrase. Another asked that we allow the Exchange to use documentation of immigration status to positively verify residency.

Response: We are removing the word "alone" from §155.315(d)(4) in the final rule because we do not intend for documents that provide evidence of immigration status to be used to determine State residency either alone or together with other documentation. We have also amended the phrase to allow the Exchange to positively verify residency using immigration documentation, which aligns with Medicaid regulations.

Comment: We received a number of comments regarding the verification of

incarceration status, as proposed in §155.315(d). Several commenters recommended that self-attestation of incarceration be accepted without further verification. Others believed that information or an attestation regarding incarceration should never be requested of an applicant, since such a request may be a deterrent to consumers applying for coverage through the Exchange. A smaller number of commenters questioned the availability of recent, accurate data with which Exchanges may verify incarceration status. One commenter stated that by not defining "release date," incarceration status will be difficult to verify.

Response: We acknowledge that there are challenges regarding the availability of electronic data on incarceration. However, we believe it is important for the Exchange to utilize any such data sources that are available and have been approved by HHS for this purpose, and, at the very least, accept self-attestations of incarceration status since such status is a statutory standard for eligibility to enroll in a QHP. In addition, we believe that this attestation can be collected with minimal burden on an applicant, and we expect that it will be paired with a clear explanation as to why the information is being requested. We believe that allowing for verification of incarceration status through paper documentation would increase administrative burden on the Exchange and applicants, and for these reasons, allow for the examination of paper documentation only in the event that the applicant's self-attestation is not reasonably compatible with other information provided by the individual or information in the records of the Exchange. For greater detail about the definition of incarceration, please see comment response for §155.300.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.315 of the proposed rule, with the following modifications. We added paragraph (b), which clarifies that the Exchange will validate

SSNs that are provided by individuals. In paragraph (c)(3), we changed the word "shows" to "demonstrates" in referring to what the applicant must do if the if he or she did not receive the notice within the 5 day period; this change was made to more accurately describe the obligation of the applicant. In paragraph (d)(1) and (2), we allowed the Exchange may choose whether it accepts an attestation from applicants regarding residency without further verification or examines electronic data sources for all applicants, and we clarify that the standard for approval of electronic data sources for verification of residency will be based on whether such sources are sufficiently current and accurate, and minimize administrative costs and burdens.

In paragraph (d)(3), we clarify that by referring to data sources, we mean those data sources that are available to the Exchange and that have been approved by HHS for this purpose. In paragraph (d)(3), we remove the reference to "a document that provides" before "evidence" so as not to limit the acceptable types of such evidence. We also remove the word "alone" in order to clarify that the Exchange may not use evidence of immigration status alone or together with other evidence to determine State residency. In paragraph (d)(3), we also change the term "may" to "must" to specify that if the applicant's attestation is not reasonably compatible with information in the records of the Exchange, the Exchange must examine available, approved data sources in order to verify the attestation. We also change the phrase in paragraph (d)(4) to state that evidence of immigration status may not be used to determine that an applicant is not resident of the Exchange service area.

We clarified in paragraph (f) that an inconsistency may result when electronic data is necessary for verification but is not available. We also included in paragraph (f)(1), "including through typographical or other clerical errors" to describe the causes of inconsistency. In paragraph (f)(2)(i), we changed "notify" to "provide notice to the applicant regarding" in order to

clarify the Exchange's notice standard. Also, we added language to paragraph (f)(2)(ii) to specify that all channels described in §155.405(c) of this part are acceptable for the submission of documentation to resolve inconsistencies, except for by telephone. In paragraph (f)(5)(i), we specify that the Exchange must determine the applicant's eligibility based on the information available unless such applicant qualifies for the exception provided under paragraph (g). We also add, on an interim final basis, paragraph (g), which provides a case-by-case approach to resolving inconsistencies for applicants for whom documentation does not exist or is not reasonably available.

We also made technical corrections. We redesignated paragraphs (b) through (g) as paragraphs (c) through (i). In paragraph (a), we changed the reference to paragraph (e) to paragraph (g). In paragraph (d), we changed "by" to "as follows," and changed verb tenses in (d)(1) and (d)(2). In paragraph (f)(3), we corrected the reference to paragraph (f)(3) and changed it to (f)(2)(ii). In paragraph (f)(5)(ii), we changed the word "implement" to "effectuate." We also add, on an interim final basis, paragraph (g) to provide a case-by-case exception for applicants for whom documentation does not exist or is not reasonably available.

In paragraph (h), we changed the word "plan" to "Blueprint." Throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

f. Verification process related to eligibility for insurance affordability programs (§155.320)

In §155.320, we proposed that the Exchange verify information in accordance with this section only for an applicant who is requesting an eligibility determination for insurance affordability programs.

We proposed standards related to the verification of eligibility for minimum essential coverage other than through an eligible employer-sponsored plan.

We also proposed standards for the verification of household income and family and family/household size and solicited comments regarding how best to ensure a streamlined eligibility process given underlying differences between the Treasury proposed rule and the Medicaid proposed rule. We proposed standards for the Exchange to obtain tax return data for individuals whose income is counted in calculating a tax filer's household income, and to obtain MAGI-based income for all individuals whose income is counted in calculating a tax filer's household income, in accordance with 26 CFR 1.36B-1(e), or an applicant's household income, in accordance with 42 CFR 435.603(d).

We proposed the verification process for income and household size for Medicaid and CHIP and solicited comments as to how this process could work most smoothly for both electronic and paper applications. We proposed that the Exchange must verify household size by obtaining an attestation from the application filer and accepting the attestation without further verification unless the attestation is not reasonably compatible with other information in the records of the Exchange. We also proposed the process for the Exchange to verify MAGI-based household income by referring to the procedures described in Medicaid proposed regulations at 42 CFR 435.948 and 42 CFR 435.952 and CHIP regulations at 42 CFR 457.380. We solicited comments as to how the Exchange process and the Medicaid and CHIP processes can be streamlined to ensure consistency and maximize the portion of eligibility determinations that can be completed in a single session.

Similar to Medicaid and CHIP, we proposed that for advance payments of the premium tax credit and cost-sharing reductions, the Exchange direct an application filer to attest to the

specific individuals who comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions, and that the Exchange accept an application filer's attestation of family size without further verification, unless the attestation and any other information in the records of the Exchange are not reasonably compatible. We further proposed the basic verification process for annual household income. We proposed that the Exchange compute, in accordance with specific rules for Medicaid and CHIP and specific rules for eligibility for advance payments of premium tax credits and cost-sharing reductions, annual household income for the family defined by the application filer and that the application filer validate this information by attesting whether it represents an accurate projection of the family's household income for the benefit year for which coverage is requested. We proposed that if tax data are unavailable, or if an application filer attests that the Exchange's computation based on available tax data does not represent an accurate projection of the family's household income for the benefit year for which coverage is requested, the Exchange direct the application filer to attest to the family's projected household income. We proposed that if such an attestation is not reasonably compatible with the data obtained by the Exchange or if the data is unavailable, the Exchange must follow procedures for the alternate verification process. We also proposed that the Exchange use an alternate process for determining income for purposes of advance payments of the premium tax credit and cost-sharing reductions for tax filers in certain situations. We proposed that in situations in which an application filer attests that a tax filer's annual household income has increased or is reasonably expected to increase from the information obtained from his or her tax return, the Exchange accept the application filer's attestation without further verification, with limited exceptions. We also proposed to codify the minimum standards for circumstances under which an application filer who is attesting to a decrease in income for a tax

filer, or is attesting to income because tax return data is unavailable, may utilize an alternate income verification process that includes annualized data from MAGI-based income sources and other electronic data sources approved by HHS. We solicited comment on what situations should justify use of the alternate process.

We also proposed the verification process the Exchange must follow for a tax filer whose annual household income decreases by a certain amount. We proposed that if the Exchange requests additional documentation to resolve an inconsistency and the application filer has not responded to a request for additional information from the Exchange within a 90 day period and data sources indicate that an applicant in the tax filer's family is eligible for Medicaid or CHIP, the Exchange may not provide the applicant with eligibility for advance payments of the premium tax credit or cost-sharing reductions. We proposed that if at the end of the 90 day period the Exchange is unable to verify the application filer's attestation, the Exchange must determine the applicant's eligibility based on available data, in accordance with the process proposed in §155.310(g) and §155.330(f). In addition to the above standards, we proposed that the Exchange provide education and assistance to an application filer regarding the verification process for income and family/household size and solicited comments on strategies that the Exchange can employ to ensure that application filers understand the validation process and provide well-informed validations and attestations.

For other situations in which the Exchange remains unable to verify an application filer's attestation, we proposed that the Exchange determine eligibility for advance payments of the premium tax credit and cost-sharing reductions for tax filers who do not meet the criteria for the alternate income verification process based on the tax filer's tax data. We also proposed that if an application filer does not respond to a request for additional information from the Exchange

and data sources described in paragraph (c)(1) indicate that an applicant in the primary tax filer's family is eligible for Medicaid or CHIP, the Exchange will not provide the applicant with eligibility for advance payments of the premium tax credit or cost-sharing reductions based on the application.

We proposed that the Exchange verify whether an applicant who requested an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions is enrolled in an eligible employer-sponsored plan by accepting his or her attestation without further verification, except in cases in which information is not reasonably compatible with other data provided by the applicant or in the records of the Exchange. We solicited comments as to whether the Exchange could assume that an applicant would understand whether or not he or she is enrolled in an eligible employer-sponsored plan, and therefore rely upon applicant attestation in this area. We proposed that the Exchange may request additional information regarding whether an applicant is enrolled in an eligible employer-sponsored plan if an applicant's attestation is where an applicant's information is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. We solicited comments regarding the best data sources for this element of the process.

In addition, we proposed that the Exchange must request from an applicant who requests an eligibility determination for advance payments of the premium tax credit or cost-sharing reductions to attest to his or her eligibility for qualifying coverage in an eligible employer-sponsored plan. We further proposed that the Exchange verify this information. We solicited comments regarding how the Exchange may handle a situation in which it is unable to gain access to authoritative information regarding an applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan. We invited comment on the timing and reporting of

information needed to verify whether an employed applicant is eligible for qualifying coverage in an eligible employer-sponsored plan, and the best methods for facilitating interaction among Exchanges for this purpose. Specifically, we solicited comment regarding two specific methods for the submission and collection of information regarding eligibility for qualifying coverage in an eligible employer-sponsored plan—the employee template and the employer central database.

Comment: Many commenters questioned the criteria for using the alternative verification process to verify household income; in particular, commenters argued against the standard proposed §155.320(c)(3)(iv) that limits the ability of the Exchange to follow the alternative verification process to situations in which tax data is not available, family size or filing status has changed or is reasonably expected to change, an applicant has filed for unemployment benefits, or when an application filer attests that the tax filer's annual household income has decreased or is reasonably expected to decrease from tax data obtained by the Exchange by 20 percent or more. Comments focused on the 20 percent threshold, which commenters believed was too high, particularly given the relatively low incomes of the population likely to request an eligibility determination for financial assistance, and would thus result in a substantial group of tax filers being unable to obtain advance payments of the premium tax credit commensurate with their household income, regardless of whether they were able to substantiate a lower income. Commenters supported a percentage threshold lower than 20 percent or a different measure altogether.

Response: We recognize that utilizing the 20 percent minimum would result in a substantial number of tax filers who are unable to afford coverage due to significant changes in income and that we should modify our proposed rule so that an eligibility determination matches, as closely as possible, a tax filer's true circumstances. We note that section 1412(b)(2) of the

Affordable Care Act describes that the Secretary must provide procedures for making eligibility determinations for advance payments of the premium tax credit, "in cases where information included with an application demonstrates substantial changes in income…or other significant changes affecting eligibility". The statute outlines a minimum set of circumstances that meet this standard; we interpret the statutory 20 percent or more decrease as congressional direction that any decrease of that magnitude must trigger an alternate verification process, but not to limit the Secretary's discretion to identify other significant changes in income that trigger an alternate verification process. We codified this provision in the proposed rule at §155.320(c)(3)(iv), along with the other minimum standards, and solicited comments as to whether this was an appropriate standard, or whether we should establish a different threshold.

Based on an analysis performed by the Secretary[5], a family of four with household income of 200 percent of the FPL ($47,018 using projected 2014 figures) is projected to have a total premium, after advance payments, of $247 per month. A five percent decrease in income from $47,018 is $44,667 (190 percent of the FPL), would correspond to a total premium, after advance payments, of $217 per month, for a total difference in premium of around $360 per year. In addition, while advance payments are sensitive to every dollar of income, cost-sharing reductions are not; consequently, even very small changes that move a person across a threshold (150 percent FPL, 200 percent FPL, or 250 percent FPL) can be very significant. For example, based on the same figures cited above, the difference in cost-sharing between a family at 190 percent FPL and a family at 200 percent FPL is $1,000 per year, due to the change in eligibility for cost-sharing reductions at 200 percent FPL. The difference is $2,000 around 250 percent FPL, which is the upper limit for cost-sharing reductions based solely on household income. We believe that these are significant changes, which will be critical to recognize in order to ensure

[5] http://www.healthcare.gov/law/resources/reports/premiums01282011a.pdf

that eligible individuals can afford coverage.

Therefore, in this final rule, we specify that the Exchange must use information other than tax data to verify income in cases in which an applicant attests that a change has occurred or is reasonably expected to occur, and as such, a tax filer's annual household income has decreased or is reasonably expected to decrease from his or her tax data. As noted above, we believe that any change in household income constitutes a change in circumstances that meets the "significant changes affecting eligibility" standard identified in section 1412(b)(2) of the Affordable Care Act, given the sensitivity of the advance payment formula and the potential for large variations in cost-sharing reductions with small shifts in income. This approach to implementing section 1412(b)(2) is further reinforced by the fact that requiring the Exchange to conduct an individualized analysis as to whether each tax filer's circumstances constitute a "significant change" in accordance with the statute would place a substantial administrative burden on the Exchange; to conduct such case-by-case analyses, the Exchange would need to apply different procedures to subgroups of tax filers, specifically around cost-sharing reduction thresholds. Overall, we believe that using this standard will increase the accuracy of income verification, the accuracy of eligibility determinations, and the equity of the process for tax filers without significantly increasing the administrative burden on the Exchange.

We also make a change to another criterion for the alternate verification process described in §155.320(c)(3)(iv)(B); we include that when an applicant attests that members of the tax filer's family have changed or are reasonably expected to change, he or she qualifies for an alternate verification process. We add this provision in order to account for a situation in which the family members are different but the number of family members remains the same.

In §155.320(c)(3)(v), we describe the alternate verification process for decreases in

household income or situations in which tax data are unavailable. We move the language from §155.320(c)(3)(ii)(C) of the proposed rule, which specified that the Exchange accept an applicant's attestation of projected annual household income, unless it was not reasonably compatible with tax data, to this section, and replace "reasonably compatible" with a standard of a decrease of ten percent or less from the tax data. We redesignate §155.320(c)(3)(v) of the proposed rule as §155.320(c)(3)(vi), which specifies the verification process for larger decreases and situations in which tax data are unavailable. Taken together, these revisions address commenters' concerns regarding inequities in the proposed verification process by ensuring that there are procedures under which a tax filer can obtain advance payments of the premium tax credit commensurate with their household income when changes have occurred or are reasonably expected to occur, regardless of the size of any such changes.

Comment: We received many comments recommending that HHS further define the term "reasonably compatible", as used throughout proposed §155.320(c) as the standard for assessing whether verification can be considered complete, or if additional information is necessary. Commenters suggested various approaches to establishing a more detailed standard, including, in the case of income, the use of an acceptable percentage of deviation between the amount reflected by the data and an application filer's attestation. Others recommended that the Exchange should consider an application filer's attestation to income reasonably compatible with electronic data even if there is a difference in the data and an application filer's attestation, as long as the difference does not significantly impact eligibility. Some commenters recommended that Exchanges maximize the use of self-attestation without further verification, which would speak to setting the "reasonably compatible" threshold at a higher level. Other commenters requested that HHS establish a standard that allows for flexibility in implementation, and a few

commenters recommended removing the "reasonably compatible" standard altogether. A few commenters recommended providing that the Exchange must always request additional evidence with the goal of achieving a more accurate projection of income or family size.

Response: When assessing comments recommending that HHS define the "reasonably compatible" standard proposed in §155.320(c), we weighed our desire for Exchange flexibility with the goal of providing greater consistency in income verification for applicants across Exchanges and a more streamlined process, in order to reduce burden for applicants and Exchanges. However, based on the comments received, we recognize that there is a need to define a specific threshold within which the Exchange would accept an applicant's attestation regarding projected annual household income, as opposed to engaging in a more burdensome process. Accordingly, as discussed in the previous response, the final rule specifies that the Exchange will accept an applicant's attestation to projected annual household income without further verification if it is no more than ten percent below his or her tax data. We believe that using this threshold will result in eligibility determinations that are accurate while limiting the administrative burden associated with completing additional verification processes for smaller decreases in income. We believe that this is particularly important given the age of available tax return information at the point of open enrollment, as well as the volatility in income among households that are likely to request an eligibility determination for insurance affordability programs. In particular, we believe that it is critical to focus the limited resources of Exchanges on ensuring that larger changes are subjected to additional scrutiny.

In addition, we clarify that the process proposed in §155.320(c)(3)(i) for verification of family size for purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions follows the process specified in section 1411 of the Affordable Care Act,

which specifies that the Secretary verify family size with the Secretary of the Treasury, and then implement alternative procedures to the extent that a change has occurred or tax data are unavailable.

First, in paragraph (c)(1)(i)(A), the Exchange will request tax return data including data regarding family size. In paragraph (c)(3)(i)(A), we specify that an applicant will attest to the individuals that comprise an applicant's family for advance payments of the premium tax credit and cost-sharing reductions. We add paragraph (c)(3)(i)(B) to clarify that if an applicant attests that tax data represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested (that is, that no change has occurred or is reasonably expected to occur), the Exchange must use the family size information from the tax data to determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions. And in paragraph (c)(3)(i)(C), we specify that if tax data are unavailable, or an applicant attests that a change has occurred or is reasonably expected to occur, and as such, 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 accept his or her attestation to family size without further verification, unless it is not reasonably compatible with other information provided by the applicant or in the records of the Exchange.

In paragraph (c)(3)(i)(C), we clarify that the assessment of reasonable compatibility is not with respect to the tax data, as paragraph (c)(3)(i)(C) is designed to address situations in which it is already clear that tax data are unavailable or not representative. We then maintain the provisions from the proposed rule specifying that if information regarding family size is not reasonably compatible, the Exchange must first utilize data obtained through other electronic data sources, and if that is unsuccessful, follow the inconsistency process in §155.315(f).

Comment: We received comments suggesting that HHS clarify aspects of the income verification process in proposed §155.320; in particular, commenters asked that the final rule specify the sequencing of the process, so that a clear order for the execution of steps for Medicaid, CHIP, and advance payments of the premium tax credit and cost-sharing reductions is established. Commenters also asked that HHS allow Exchanges greater flexibility around the use of electronic data to verify household income. For example, one commenter recommended that in the event an applicant's current income data places them well below the income level for eligibility for advance payments of the premium tax credit or cost-sharing reductions, the Exchange not be required to also obtain the applicant's tax return data. Others questioned the overall usefulness of available tax return data given its age, and asked that Exchanges be permitted to look only at available current income data sources to verify household income for all insurance affordability programs.

Response: We acknowledge commenters' desire to further streamline and simplify the eligibility and enrollment process by avoiding unnecessary steps to verify applicant information. Sections 1402(f)(3), 1411(b)(3) and 1412(b)(1) of the Affordable Care Act provide that data from the most recent tax return information available must be the basis for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions to the extent such tax data is available. HHS is working closely with Treasury and IRS to ensure that such data is readily accessible by the Exchange, to assist in facilitating the completion of an eligibility determination in a single, online session. We believe that the regulation is not the place to lay out detailed, sequenced steps for verifying household income. As such, in §155.320(c)(3)(ii), we have made changes to allow the Exchange flexibility when sequencing the verification of annual household income; we altered the text such that the Exchange may present the applicant with his

or her projected annual household income computed from the tax return information prior to requiring an attestation from the applicant or, in the alternative, to allow the Exchange to take an attestation from the applicant regarding a tax filer's projected annual household income and then verify whether the attestation is supported by the tax return information described in §155.320(c)(3)(i). Overall, we intend for the regulation to be neutral with regard to the sequencing of operations, and will provide such operational details through guidance.

Comment: Commenters asked HHS to clarify whether, when verifying annual household income as described in proposed §155.320, the Exchange must rely on a tax filer's attestation to make a final determination of household income when the attestation and tax data are reasonably compatible, or whether the Exchange must rely on tax data.

Response: We acknowledge commenters' concerns that the proposed regulation text at §155.320(c)(3)(ii) does not clearly describe the process the Exchange must follow in the event that the applicant attests that the income in the tax data represents an accurate projection of the household's projected annual household income. In this final rule, we include a provision in §155.320(c)(3)(ii)(B) which describes that, in this situation, the Exchange must determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions based on the income data from his or her tax return.

Comment: A few commenters asked for clarification as to when it is appropriate to accept self-attestation of income. We also received comments asking for clarification on our use of self-attestations throughout the verification processes described in §155.315 and §155.320.

Response: The Exchange may accept an applicant's attestation of her or her projected annual household income in a number of instances during the income verification process; however, it is important to note, that for purposes of verification of income for determining

eligibility for advance payments of the premium tax credit and cost-sharing reductions, the Exchange will never accept such an attestation without attempting to acquire tax data. Those instances in which the Exchange may accept an attestation without further verification when an application attests that as a result of a change or an expected change, a tax filer's income has increased, by any amount, above the projected annual household income calculated by the Exchange based on tax data, as described in §155.320(c)(3)(iii); and when an applicant attests that as a result of a change or an expected change, a tax filer's projected annual household income has decreased or is reasonably expected to decrease from the projected annual household income calculated based on tax data by ten percent or less, as described in §155.320(c)(3)(v).

In response to comments regarding the use of self-attestation in the verification process, the processes described are designed to confirm information to the extent necessary to provide eligibility. In situations in which the Exchange uses self-attestation without further verification as the basis of eligibility, we have determined that this approach yields valid data and does not pose unacceptable levels of risk. We believe that this approach is particularly important in order to promote a seamless, real-time experience for as many applicants as possible. It is also important to note that strong program integrity protections will be in place and that all attestations will be provided under penalty of perjury.

Comment: We received comments asking which procedures the Exchange must follow when an individual's unverified income meets the Medicaid or CHIP income threshold.

Response: As indicated in §155.320(c)(2)(ii) of the proposed rule, if an individual's unverified current income meets the Medicaid or CHIP income threshold, the Exchange would verify his or her household income in accordance with Medicaid or CHIP rules specified in 42 CFR 435.948 and 42 CFR 435.952. Similarly, if an individual attests to income in the Medicaid

or CHIP eligibility range, the Exchange would need to follow the procedures outlined in 42 CFR 435.948 and 42 CFR 435.952, since such individual would not be eligible for the alternative verification process, as indicated in §155.320(c)(3)(iv). We maintain these provisions in this final rule.

Comment: We received several comments requesting greater integration and alignment in standards and processes for verifying family/household size and household income across insurance affordability programs. Some asked for States to be given flexibility to align standards across insurance affordability programs. Commenters also recommended specific changes facilitating a closer alignment of the rules for determining family/household size and household income between Medicaid, CHIP and advance payments of the premium tax credit and cost-sharing reductions. Some recommended full integration, utilizing identical standards across insurance affordability programs.

Response: Throughout §155.320(c), the standards for verification of family size and income for determining eligibility for advance payments of the premium tax credit and cost-sharing reductions closely follow the rules set forth in sections 1411 and 1412 of the Affordable Care Act and section 36B of the Code. We sought to align as closely as possible with the standards established for Medicaid and CHIP, but given statutory standards, we were limited in the degree of alignment we could achieve.

With respect to family/household income and household size, we note that Medicaid/CHIP and advance payments both start with the family size and income counting rules in section 36B of the Code. From there, there are three key differences in how income must be measured in Medicaid/CHIP and for advance payments and cost-sharing reductions. First, as noted in the proposed rule, section 1902(e)(14)(H) of the Social Security Act, as added by

section 2002 of the Affordable Care Act, specifies that Medicaid eligibility will continue to be based on "point-in-time", or current monthly income, while eligibility for advance payments of the premium tax credit and cost-sharing reductions is based on annual income. This is reflected in 42 CFR 435.603(h)(1). Second, 42 CFR 435.603(b) and (f) specifies that in certain situations, Medicaid and CHIP follow different household composition rules from those in section 36B of the Code, which then lead to counting income for a different group than would be counted for advance payments of the premium tax credit and cost-sharing reductions. These situations are discussed in detail in the preamble associated with 42 CFR 435.603.

Third, 42 CFR 435.603(e) specifies that there are some exceptions to the use of the income counting rules of section 36B of the Code for purposes of eligibility for Medicaid and CHIP. These include special treatment for lump sum payments, scholarships, awards, or fellowship grants used for educational purposes and not for living expenses, and certain types of American Indian and Alaska Native income.

Aside from the different time standard, in the majority of cases, the rules for counting household income and household/family size are the same across insurance affordability programs. In addition, we note that 42 CFR 435.603(i) specifies that in a situation in which an applicant is over the income threshold for Medicaid, but is under the income threshold for advance payments of the premium tax credit, the Medicaid agency will determine Medicaid eligibility using section 36B rules, which would likely result in Medicaid eligibility in most situations. We have also added an additional provision in §155.345(e), which is discussed in the comment and response associated with that section.

Lastly, we note that throughout subpart D, we use "household size" for purposes of Medicaid and CHIP, in order to align with Medicaid and CHIP regulations, and "family size" for

purposes of advance payments of the premium tax credit and cost-sharing reductions, in order to align with Treasury regulations. To clarify this, we added §155.320(c)(3)(viii), which specifies that for purposes of advance payments of the premium tax credit and cost-sharing reductions, "family size" means family size as defined in section 36B(d)(1) of the Code.

Comment: We received a number of comments related to current income sources to be used by the Exchange in verifying household income. Commenters asked us to define those current income sources that the Exchange will use in the process proposed in §155.320(c)(1)(ii). Others asked whether current income information would be available via the Federally-managed data services hub.

Response: Under §155.320(c)(1)(ii) of the proposed and this final rule, the Exchange must obtain the most current income data from those data sources described in existing Medicaid regulations at 42 CFR 435.948(a). In order to access this current income data, we anticipate that the Exchange will leverage State Medicaid and CHIP agencies' existing relationships with current income sources, but we are also exploring the potential for supporting connections to sources of current income data through the data services hub.

Comment: Several commenters had specific questions related to services available to support the income verification process through the data services hub. Specifically, commenters asked which data elements from the tax return would be available from the IRS via the data services hub, and recommended that individual data elements (for example, wages, profit and loss from business, deductions) would be more useful in verifying household income than a single MAGI data element.

Response: We are working to identify those services which will be available to Exchanges to support the income verification process and will provide further detail in future

guidance. We note that the section 6103(l)(21) of the Code identifies general categories of tax data that will be available for purposes of determining eligibility in insurance affordability programs. In addition, these categories are discussed in the response to question 8 in HHS' November 29, 2011 document titled "State Exchange Implementation Questions and Answers".[6]

Comment: We received comments related to the treatment of American Indian and Alaska Native income. Some asked whether current State arrangements around the treatment of such income will be allowed to stand under the Exchange; others asked that the exemption for American Indian and Alaska Native income be referenced in the Exchange final rule and that materials be available to consumers so they can understand the availability of such exemptions.

Response: In §155.320(c)(1)(ii) of the proposed rule, we reference 42 CFR 435.603(d) for purposes of income eligibility for Medicaid, which incorporates the applicable income exemptions for American Indians and Alaska Natives described under 42 CFR 435.603(e)(3). This regulatory reference addresses the treatment of these exemptions and the future of existing arrangements with regard to American Indian and Alaska Native income with respect to Medicaid. We note that these income exemptions do not apply when verifying annual household income for advance payments of the premium tax credit and cost-sharing reductions, because the Affordable Care Act establishes specific definitions of "household income" and "MAGI" to use for determining eligibility for these benefits. Because of the statutory limits on the definition of household income for advance payment of premium tax credits and cost-sharing reductions, this final rule maintains the proposal to follow the rules described in section 36B of the Code.

Comment: We received a comment recommending that HHS clarify that, for purposes of obtaining data regarding MAGI-based income for purposes of Medicaid and CHIP eligibility, the Exchange will initially request data from data sources described in 42 CFR 435.948(a), not from

[6] http://cciio.cms.gov/resources/files/Files2/11282011/exchange_q_and_a.pdf.pdf

the applicant.

Response: The specific sequencing of the process for collecting and verifying relevant information is subject to future operational analysis, and that we anticipate providing future guidance on this topic, including through the model electronic application.

Comment: We received a number of comments related to proposed §155.320(c)(4), which provides that the Exchange must provide education and assistance to an application filer regarding the family/household size and household income verification process. Several commenters suggested specific standards for the format and content of consumer education and assistance materials. Some commenters asked that a Federal standard for such materials be developed for Exchanges, and others advised that HHS encourage Exchanges to provide information specific to the alternative income verification process to ensure a smooth verification process.

Response: There are several provisions throughout this final rule which provides that the Exchange must provide consumer tools and education related to the eligibility and enrollment process, in addition to the standard described in §155.320(c)(4), including a calculator and other tools, described in §155.205, and information regarding advance payments of the premium tax credit, described in §155.310(d)(2)(iii). We expect to issue future guidance on this topic.

Comment: We received comments asking if the Exchange would have access to all child support data; and if so, suggesting that the Exchange must abide by specific data safeguards.

Response: The Exchange would not be required to have access to child support data for purposes of verifying annual household income. Regardless, for data collected by the Exchange, privacy and security protections, described in §155.260 of this final rule, and standards for electronic transactions, described in §155.270 of this final rule, would also apply.

Comment: Several commenters supported the proposal in §155.320(d) for the Exchange to utilize self-attestation by the employee to verify enrollment in an eligible employer-sponsored plan. One commenter stated that HHS should give States the flexibility to use self-attestation or to use other methods of verification.

Response: We accept these comments and maintain this provision in the final rule. Section 1411(d) gives authority to the Secretary to determine the appropriate means to verify certain information that the applicant must submit in accordance with section 1411(b)(4). We note that §155.315(h) of this subpart allows State flexibility, subject to approval by HHS, based on a finding that the alternative approach meets certain standards described in that section.

Comment: Several commenters asserted that individuals enrolled in continuation coverage under the Consolidated Omnibus Budget Reconciliation Act (COBRA) or in an eligible employer-sponsored plan should have the opportunity to be conditionally determined eligible for advance payments of the premium tax credit and cost-sharing reductions, subject to termination prior to enrollment in a QHP. These commenters reasoned that individuals should not be forced into uninsured status in order to obtain a determination of eligibility for tax credits and risk remaining uninsured if they are found ineligible and the enrollment period for electing COBRA or coverage in an eligible employer-sponsored plan passes.

Response: Section 36B(c)(2)(C)(iii) of the Code states that an individual who is enrolled in an eligible employer-sponsored plan is not eligible for advance payments of the premium tax credit; because of the statutory prohibition on providing cost-sharing reductions for any month that is not a month for which the enrollee is eligible for premium tax credits, this bar also applies to eligibility for cost-sharing reductions. However, while an individual must terminate coverage in his or her employer-sponsored plan prior to the period for which he or she actually receives

advance payments of the premium tax credit and/or cost-sharing reductions, we clarify that the individual need not terminate coverage to receive an eligibility determination that he or she is eligible to receive these payments and reductions. Accordingly, we have amended the language in §155.320(d)(1) of this final rule to clarify that an attestation regarding enrollment in qualifying coverage in an eligible employer-sponsored plan should be based on the applicant's reasonable expectation of enrollment in the benefit year for which coverage is requested.

Comment: One commenter noted that the language in proposed §155.320(d) seems to indicate that the decision whether or not the Exchange must verify beyond an applicant's attestation regarding enrollment in an eligible employer-sponsored plan is within the discretion of an Exchange, and requested clarification regarding whether this was an intentional wording.

Response: We have amended the regulatory text to reflect the standard that an Exchange must verify an applicant's attestation using electronic data sources to the extent that an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange.

This change is consistent with equivalent amendments made in this subpart, and provides that, if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through electronic data sources. As discussed in the proposed rule, examining data sources, when available, will help minimize the need to request paper documentation from applicants, and the burden for Exchanges to process such documentation. A more detailed explanation of the change from "may" to "must" can be found in the comment and response to §155.315. We also plan to release guidance for States regarding electronic data sources to support this verification.

Comment: Commenters suggested a variety of operational solutions for carrying out the

verification of an applicant's eligibility for and/or enrollment in an eligible employer-sponsored plan. These comments were largely in response to the accompanying preamble discussion regarding the two potential data sources an Exchange may use to support this verification - the employer/employee template and the central database. Several commenters expressed support for or against the template and central database options. A large group consisting of consumer advocacy groups, a labor union and a think tank expressed support for the standard template option. Each of these commenters added that employees should not be required to provide information regarding minimum value because this information is not readily accessible to employees. One commenter requested that HHS provide that employers must submit information regarding eligibility for and enrollment in employer-sponsored plans to Exchanges on an annual basis. One commenter said HHS should provide States with the option to develop algorithms to determine who can be expected to have access to qualifying coverage in an eligible employer-sponsored plan using the size of the applicant's employer and industry type instead of creating a new database. Commenters also supported the goal of leveraging existing data sources for the purposes of verifying eligibility for qualifying coverage in an eligible employer-sponsored plan. One commenter said that HHS should give States the flexibility to verify eligibility for qualifying coverage in an eligible employer-sponsored plan using already-existing data. One commenter stated that HHS should have employee W-2 forms available as a verification source.

Response: We continue to consult with the Departments of Labor and Treasury regarding the optimal solution for gathering information for the purposes of verification of eligibility for qualifying coverage in an eligible employer-sponsored plan and will issue guidance on this topic. Both the template and database options we described in the proposed rule are being considered as operational solutions. We are also considering ways in which an individual could gather

information from his or her employer for the purposes of this verification. A combination of these methods could provide the most accurate and reliable results, while gathering information from both of the relevant information sources—employees and employers. We are also considering additional options in which employees seeking coverage could provide other sources of documentation from his or her employer that could verify eligibility. We plan to issue guidance outlining one or more possible methods for comment that will help guide the collection of information necessary to verify eligibility for qualifying coverage in an eligible employer-sponsored plan. However, it should be noted that any database option may rely on voluntary submission of information regarding employee eligibility for qualifying employer-sponsored coverage by employers. Further, HHS acknowledges that building the functionality required to collect and retain information regarding employer-sponsored insurance coverage will be time and resource-intensive, and is therefore is considering options for an interim approach for verification of eligibility for qualifying coverage in an eligible employer-sponsored plan. We plan to describe these interim options in forthcoming guidance. We also note that it is anticipated that initial guidance under 6103(l)(21) of the Code will not provide for sharing the contents of an applicant's Form W-2 with the Exchange.

Comment: Some commenters said the Federal government should perform verification of eligibility for qualifying coverage in an eligible employer-sponsored plan as a service to States. These commenters cited limitations on the ability of States to perform this verification. One commenter said that States with no individual income tax, specifically, would have difficulty making affordability determinations.

Response: In the State Exchange Implementation Questions and Answers released on November 29, 2011, we indicated that we are exploring how the Federal government could

manage services for verification of employer-sponsored minimum essential coverage. We note, though, that we do not believe that the absence of an individual State income tax return poses an obstacle to computing affordability, since the income verification process in §155.320(c)(3) of this final rule does not require the use of State income tax information.

Comment: One commenter stated that, in the case of an inconsistency between an applicant's attestation and internal Exchange records, the burden to produce further documentation should be on the employee, not the employer.

Response: We believe our proposed regulation followed the commenter's recommendation because the employee is the applicant. Section 155.315(f)(2)(ii) of this final rule describes that an applicant must provide further documentation if the applicant's attestation is inconsistent with other information sources.

Comment: One commenter requested that HHS must establish two distinct processes for the determination of eligibility for advance payments of the premium tax credit by Exchanges under proposed §155.320 and for the assessment of employer penalties by the Treasury.

Response: The statute makes clear that the two processes are distinct. Under sections 1411 and 1412 of the Affordable Care Act, the Exchange will make eligibility determinations for advance payments of the premium tax credit and cost-sharing reductions, notify employers that a payment may be assessed and that the employer has a right to appeal to the Exchange, and provide information to the Treasury. The assessment of shared responsibility payments under section 4980H of the Code is within the jurisdiction of the Treasury.

Comment: One commenter concurred with the language of §155.320 of the Exchange Eligibility proposed rule, which provides that the Exchange must verify information for only those applicants seeking eligibility determinations for insurance affordability programs in order

to minimize multiple employer interactions with the Exchange.

Response: Verification of eligibility for qualifying coverage in an eligible employer-sponsored plan is necessary only when indicated as necessary in accordance with the statute. An Exchange is not required to verify eligibility for qualifying coverage in an eligible employer-sponsored plan for an applicant who did not request an eligibility determination for all insurance affordability programs.

Comment: One commenter asserted that HHS should declare that all employer-sponsored insurance offered to American Indians and Alaska Natives fails the affordability and minimum value standards. The commenter reasoned that information regarding affordability and minimum value will be difficult for this type of applicant to provide. In addition, the commenter stated that if an individual is eligible to receive services through the Indian Health Service (IHS), including eligibility for services from an IHS facility, or for services from a tribe or tribal organization, or Urban Indian Organization, the Exchange should not attempt to verify an attestation regarding eligibility for qualifying coverage in an eligible employer-sponsored plan because this population is exempt from the standard to maintain minimum essential coverage.

Response: While we recognize that certain data elements requested from applicants for the purposes of this verification may be challenging to obtain, we believe that a wholesale exception for American Indians and Alaska Natives is not warranted or permissible under the statute, and are not providing for such an exception in this final rule.

Comment: One commenter requested clarification on the issue of full-time employment and its relationship to eligibility for qualifying coverage in an eligible employer-sponsored plan. Specifically, the commenter asked whether full-time status will be requested during the verification process, whether the Exchange will consider it when making eligibility

determinations for advance payments of the premium tax credit, and whether the affordability test depends on whether the applicant is a full-time employee. In addition, the commenter requested clarification regarding notification and how an Exchange should manage eligibility determinations for applicants with multiple employers.

Response: Section 1411(b)(4)(B) of the Affordable Care Act specifies that an applicant must provide information including, "whether the enrollee or individual is a full-time employee." With that said, the affordability test and the determination of whether an applicant is eligible to receive advance payments of the premium tax credit and/or cost-sharing reductions is not dependent on the full-time status of the employee. Rather, this information is relevant for Treasury's determination as to whether a shared responsibility payment under section 4980H of the Code applies to an employer. Also, we note that in the case of an applicant who has more than one employer, the Exchange will evaluate information from existing data sources regarding all of the applicant's employers to determine eligibility for qualifying coverage in an eligible employer-sponsored plan.

Comment: One commenter requested clarification regarding whether the Exchange will use tax data to ensure affordability of coverage for employees under proposed §155.320. The commenters asked whether the employer may use wage data, instead of household income data, in its affordability determination.

Response: The Exchange will use the projected annual household income verified through the process described in §155.320(c)(3) of this final rule to compute the affordability of available coverage through an eligible employer-sponsored plan. The question of whether an employer may use wage data in determining whether its offered coverage meets affordability criteria is beyond the scope of this rule, and is within the authority of the Department of the

Treasury. In September 2011, the Department of the Treasury released IRS Notice 2011-73 (2011-40 I.R.B. 474) requesting comments on a potential safe harbor permitting employers to use an employee's W-2 wages in determining the affordability of employer-sponsored minimum essential coverage for purpose of the employer shared responsibility provisions under Code section 4980H. In February 2012, the Department of the Treasury released Notice 2012-17 (issued jointly with HHS and the Department of Labor) confirming that it intends to issue proposed regulations or other guidance providing for this safe harbor[7].

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.320 of the proposed rule, with the following modifications. In paragraph (c)(2)(i)(A), we adopted new language to describe the verification of household size for Medicaid and CHIP, in order to align with the Medicaid Eligibility final rule. We redesignated paragraph (c)(3)(i)(B) as paragraph (c)(3)(i)(C), and added paragraph (c)(3)(i)(B), which clarifies that if an applicant attests that tax data represents an accurate projection of a tax filer's family size for the benefit year for which coverage is requested, the Exchange must use the family size information from the tax data to determine the tax filer's eligibility for advance payments of the premium tax credit and cost-sharing reductions. We also added paragraphs (c)(3)(i)(C) and (D), which clarifies that this paragraph applies when tax data are unavailable or when a change has occurred or is reasonably expected to occur such that the data does not represent an accurate projection of family size; and clarifies that the assessment of reasonable compatibility is with respect to data other than that from the tax return.

We also make a technical change to §155.320(c)(2)(i)(B) to state that the Exchange "must," rather than "may," examine electronic data sources if information is found to be not

[7] Frequently Asked Questions from Employers Regarding Automatic Enrollment, Employer Shared Responsibility, and Waiting Periods. February 9, 2012: http://www.dol.gov/ebsa/newsroom/tr12-01.html

reasonably compatible. This change was made in order to align with verification of other applicant information, and so that in the event the Exchange accepts an applicant's attestation without further verification but such attestation is not reasonably compatible with other information provided by the application filer or contained in the records of the Exchange, the Exchange must examine available data sources to verify the attestation. If the information in the data sources cannot be used to verify the attestation, the Exchange must request additional documentation in accordance with Medicaid regulations at 42 CFR 435.952. This change was also made in order to align with changes made to the Medicaid regulations regarding verification of household size.

We redesignated paragraph (c)(3)(ii)(B) as paragraph (c)(3)(ii)(C), and removed the phrase "is requested and accept the application filer's attestation without further verification, except as provided in paragraph (c)(3)(ii)(C) of this section" in order to clarify that the Exchange must proceed in accordance with the procedures in paragraph (c)(3)(ii)(C) after receiving such an attestation.

We also added paragraph (c)(3)(ii)(B), which provides that the Exchange must request the applicant to attest regarding his or her projected annual household income. We have also added paragraph (c)(3)(ii)(C) which clarifies that if an applicant's attestation indicates that the tax data represents an accurate projection of a family's household income for the benefit year for which coverage is requested, the Exchange must use the household income information from the tax data to determine his or her eligibility for advance payments of the premium tax credit and cost-sharing reductions. In paragraph (c)(3)(iii)(B), we changed the term "may" to "must" to specify that if the Exchange finds that information provided by an applicant is not reasonably compatible, it must examine any information available through other electronic data sources. In

paragraph (c)(3)(iv)(A), we replaced the phrase "this is as a result of an individual not being required to file" with "an individual was not required to file." In paragraph (c)(3)(iv)(B), we added that the alternate verification process is also available for a tax filer whose family composition has changed or is reasonably expected to change; we also added the phrase "or members of the tax filer's family have changed or are reasonably expected to change." In paragraph (c)(3)(iv)(C), we removed, "by more than 20 percent," and clarified that this criterion is based on an applicant's attestation that a change has occurred or is reasonably expected to occur. We added a paragraph (c)(3)(iv)(D) to allow a tax filer to qualify for the alternative verification process if 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. Omitting this provision from the proposed rule was an oversight; this basis for use of an alternate income determination process is authorized in section 1412(b)(2) of the Affordable Care Act.

We removed proposed paragraph (c)(3)(vi); given changes made to this section of the regulation, this paragraph was no longer necessary. We redesignated proposed paragraph (c)(3)(v) as paragraph (c)(3)(vi), and added a new paragraph (c)(3)(v). In paragraph (c)(3)(v) of the final rule, we specified that if a tax filer qualifies for an alternate verification process and the applicant's attestation to projected annual household income is no more than ten percent below the annual household income computed from tax data, the Exchange must accept his or her attestation without further verification. In revised paragraph (c)(3)(vi), we specified that the process in proposed paragraph (c)(3)(vi) applies if a tax filer qualifies for an alternate verification process and the applicant's attestation to projected annual household income is greater than ten percent below the annual household income computed from tax data, or if tax

data are unavailable.

In paragraph (c)(3)(vi)(C), we clarified a reference to §155.315(f) to include paragraphs (f)(1)-(4), which includes the 90 day period during which an individual may either present satisfactory documentary evidence or otherwise resolve the inconsistency. We also added paragraph (c)(3)(vi)(F), to describe that if, at the end of the 90 day period the Exchange is unable to verify the applicant's attestation and the tax data described in (c)(3)(ii)(A) is unavailable, the Exchange must notify that applicant and discontinue the advance payments and cost-sharing reductions. We added this paragraph in order to explicitly describe the procedures the Exchange must follow when there is no data on which to rely at the conclusion of the 90 day period.

We also added paragraphs (c)(3)(vii) and (c)(3)(viii), which clarify that the terms "household income" and "family size" in paragraph (c)(3) mean household income as specified in section 36B(d)(2) of the Code, and family size as specified in section 36B(d)(1) of the Code, respectively. To clarify the process for verifying eligibility for qualifying coverage in an eligible employer-sponsored plan tracks, we amended paragraph (d)(1) to state that the Exchange must also verify whether an applicant reasonably expects to be enrolled in an eligible employer-sponsored plan for the benefit year for which coverage is requested. We amended paragraph (d)(2) by changing "may" to "must", which provides that an Exchange must obtain data from electronic data sources to verify an applicant's attestation that he or she is not enrolled in an eligible employer-sponsored plan when an applicant's attestation is not reasonably compatible with other information provided by the applicant or in the records of the Exchange. We also added the word "electronic" in paragraph (d)(2) to create consistency with equivalent provisions in the subpart.

We made several technical corrections. In paragraph (a)(2), we also changed the reference

in §155.315 from paragraph (e) to (h). In paragraphs (c)(3)(i)(C) and (c)(3)(ii)(C), we clarified that when an applicant attests that tax return data is not representative of family size or household income for the benefit year for which coverage is requested, it is as a result of a change in circumstances, which aligns with section 1412 of the Affordable Care Act. In paragraph (c)(3)(iii)(A), we added "in accordance with paragraph (c)(3)(ii)(B). Proposed paragraph (c)(3)(iv)(D) was redesignated as paragraph (c)(3)(iv)(E). In paragraph (c)(3)(vi)(E), we renumbered the reference to §155.310(f) to §155.310(g), and the reference to §155.330(e)(1) through (e)(2) to §155.330(f). Throughout paragraph (c)(3), we changed references to ensure that the paragraph consistently referred to the tax filer for verification of household income for purposes of advance payments of the premium tax credit and cost-sharing reductions, in order to align with the eligibility standards. We made several changes to paragraph (f) to align with the Medicaid final rule. In paragraph (c)(2)(i)(A), we changed references to the Medicaid Eligibility final rule to account for renumbering. We also added the reference to 42 CFR 435.945 to paragraph (c)(2)(ii). Throughout the section, as in the rest of the subpart, we replaced language regarding application filers providing attestations with references to applicants providing attestations, since the language in §155.300(c) provides overarching clarification that attestations for applicants can be provided by application filers.

g. Eligibility redetermination during a benefit year (§155.330)

In §155.330, we outlined procedures for redeterminations during a benefit year. We proposed to rely primarily on the enrollee to provide the Exchange with updated information during the benefit year, and solicited comments as to whether there should be an ongoing role for Exchange-initiated data matching beyond what was proposed in the proposed rule. We also solicited comments on whether the Exchange should offer an enrollee an option to be

periodically reminded to report any changes that have occurred.

We proposed that the Exchange redetermine the eligibility of an enrollee in a QHP during the benefit year in two situations: first, if an enrollee reports updated information and the Exchange verifies it; and second, if the Exchange identifies updated information through limited data matching to identify individuals who have died or gained eligibility for a public health insurance program.

We also proposed that an individual who enrolls in a QHP with or without advance payments of the premium tax credit or cost-sharing reductions must report any changes to the Exchange with respect to the eligibility standards specified in §155.305 within 30 days of such change. Additionally, we proposed that the Exchange use the verification procedures at the point of initial application for any changes reported by an individual prior to using the self-reported data in an eligibility determination. We solicited comments on whether to allow the Exchange to limit those changes on which an individual must report, to changes in income of a certain magnitude. We noted that this provision would have no effect on whether an individual was liable for repayment of excess advance payments of the premium tax credit at reconciliation.

We also proposed that the Exchange periodically examine certain data sources that are used to support the initial eligibility process to identify death and eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if applicable. We proposed to generally limit proactive examination to these pieces of information because of the reliability of these data sources and because the identified information provides clear-cut indications of ineligibility for enrollment in a QHP and advance payments of the premium tax credit and cost-sharing reductions.

We further proposed to allow the Exchange to make additional efforts to identify and act on changes that may affect an enrollee's eligibility to enroll in a QHP to the extent that HHS

approves a plan to modify the process.[8] We indicated that such approval would be granted if HHS finds that a modification would reduce the administrative costs and burdens on individuals while maintaining accuracy and minimizing delay, that such changes would not undermine coordination with Medicaid and CHIP, and that any applicable provisions related to the confidentiality, disclosure, maintenance, or use of information will be met.

We solicited comments regarding whether and how we should approach additional data matching, whether the Exchange should modify an enrollee's eligibility based on electronic data in the event that he or she did not respond to a notice regarding the updated information, and whether there are other procedures that could support the goals of the redetermination process for changes during the benefit year.

To the extent that the Exchange verifies updated information reported by an enrollee or identifies updated information through data matching, we proposed that the Exchange determine the enrollee's eligibility and provide an eligibility notice in accordance with the process described in §155.305 and §155.310, respectively. Additionally, we proposed that changes resulting from a redetermination during the benefit year be effective for the first day of the month following the notice of eligibility determination, and proposed to allow for an exception, subject to the authorization of HHS, in which the Exchange could establish a "cut-off date" for changes resulting from a redetermination during the coverage year. We solicited comment as to whether this should or should not necessitate an authorization from HHS, and if there should be a uniform timeframe across all Exchanges. In addition, we solicited comment as to whether this is the appropriate policy for the effective date for changes.

Finally, we proposed that if the eligibility determination results in an individual being

[8] This provision is proposed in the Exchange proposed rule at 76 FR 41866 (July 15, 2011) and is addressed in this final rule at §155.330(d)(2),

ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange maintain his or her eligibility for enrollment in a QHP through the Exchange for a full month after the month in which the determination notice is sent. However, as soon as eligibility for insurance affordability materially changes, we proposed that the Exchange discontinue advance payments of the premium tax credit and cost-sharing reductions in accordance with the effective dates specified in paragraphs (e)(1) and (e)(2). We solicited comment on this topic, as well as on approaches to ensuring that transitions between insurance affordability programs do not create coverage gaps for individuals.

Comment: We received a number of comments regarding redeterminations conducted during the benefit year, as proposed in §155.330. While several commenters were supportive of the opportunity for an enrollee to have his or her eligibility redetermined prior to the annual redetermination, other commenters suggested that we limit or eliminate eligibility redeterminations during the benefit year in order to limit movement for enrollees between different insurance affordability programs and QHPs.

Response: We feel it is important for the Exchange to accept and identify changes to help ensure that an enrollee's eligibility reflects his or her true circumstances, which will help minimize repayment of excess advance payments at reconciliation when income increases, increase the affordability of coverage when income decreases, and improve program integrity. Therefore, we maintain in the final rule the opportunity for eligibility redeterminations during the benefit year.

Comment: Of those entities that commented on the process for handling changes during the benefit year described in proposed §155.330, a number suggested limiting the scope of changes on which enrollees must report; these commenters stated that requiring reporting of any

and all changes potentially impacting eligibility would substantially increase the administrative burden on both the Exchange and on enrollees. Many commenters recommended clarifying that an enrollee in a QHP who is not receiving advance payments of the premium tax credit or cost-sharing reductions would not be required to report changes in their household income or access to minimum essential coverage, as these are not considered when financial assistance is not present. Other commenters suggested limiting the reporting of changes in income; some recommended that enrollees be allowed and encouraged, but never required, to report changes in income, while others were in favor of a establishing a threshold for the reporting of income changes. Generally, those commenters who suggested limiting the changes that individuals must report also suggested that enrollees should be encouraged but not required to report all other changes impacting eligibility, such as changes in income and family size.

Response: In response to commenters' suggestions, we have altered §155.330 in this final rule regarding the policy of reporting of changes during the benefit year. First, we clarify that the Exchange may not require an enrollee who did not request an eligibility determination for insurance affordability programs to report changes related to eligibility for insurance affordability programs, including changes in income or access to minimum essential coverage. We clarify that that we mean an enrollee who, as of his or her most recent interaction with the Exchange, has not requested an eligibility determination for insurance affordability programs. In response to comments regarding which changes an enrollee must report, we amended the regulation text in the final rule to reflect different standards for changes related to income. As a result, we maintain that an individual must report a change related to eligibility for enrollment in a QHP through the Exchange (that is a change in residence, incarceration or citizenship and lawful presence) within 30 days of such change; however, we allow the Exchange to establish a

reasonable threshold below which an individual is not required to report a change in income. We believe that allowing the Exchange to limit the changes the enrollee must report will reduce confusion for enrollees and administrative burden on the Exchange, while still ensuring that significant changes are captured. With that said, we clarify that this provision does not allow the Exchange to not process changes in income that are reported by enrollees, regardless of whether they meet the threshold.

Comment: In response to our request for comment in this area, we received comments asking that Exchanges periodically remind individuals to report changes impacting their eligibility. We also received comments recommending that the Exchange provide education regarding what changes must be reported and how the reporting of changes may impact reconciliation.

Response: We have added a provision at paragraph §155.330(c)(2) of this final rule specifying that the Exchange must provide periodic electronic notifications regarding the standards for reporting changes to an enrollee who has elected to receive electronic notifications, unless he or she has declined to receive such periodic electronic notifications. We believe this will complement the provision allowing Exchanges to limit those changes in income an enrollee must report, by helping ensure that consumers are informed of the impact and importance of reporting any change to the Exchange during the benefit year. In addition, we believe that electronic communications will be minimally burdensome for the Exchange and for enrollees. Exchanges can determine the timing and frequency of such notices.

Comment: A large number of commenters supported our policy proposed at §155.330(c) directing Exchanges to periodically initiate limited data matches to identify changes in enrollees' eligibility. A few commenters asked that we preserve Exchange flexibility to expand the scope of

data matches and others asked that we provide that Exchanges must expand data matches to include income and other data; these commenters noted that such an expansion would help decrease the burden on enrollees to report changes and to decrease inaccuracy when enrollees fail to report. However, some commenters were against any Exchange-initiated data matches, including the proposal to allow Exchanges flexibility to expand the scope of data matches with HHS approval. These commenters stated that such data matches would increase movement between programs for enrollees; they also believe that enrollees are in the best position to report changes impacting their eligibility.

Response: While we acknowledge commenters' calls for Exchange flexibility to expand data matching, we believe that allowing for unlimited data matching without the application of specific standards would be undesirable. Therefore, in the final rule, we maintain the flexibility provision we proposed in the paragraph redesignated in this final rule as §155.330(d)(2), with one change: we do not require HHS approval to expand data matching, but provide that the Exchange must adhere to specific standards. We also adopt new procedures in this final rule around the verification of data obtained through such expanded data matches, which is explained in more detail in comment response below. Together, these changes will reduce burden for the Exchange and allow the Exchange to take steps to increase the accuracy of eligibility determinations as technology and data sources evolve; furthermore, the Exchange must ensure that such data matches would reduce administrative costs and burdens on individuals, maintain accuracy, minimize delay and would not undermine coordination with Medicaid and CHIP.

Comment: We received a number of comments on the provision proposed in §155.330(d), related to the verification process and enrollee notification following the Exchange identifying a change that affects eligibility. As noted previously, some commenters objected to

any Exchange-initiated data matching; these concerns were based in part on discomfort with the Exchange making changes to an enrollee's eligibility in cases in which the enrollee did not respond to a notice regarding the change. Some suggested that the Exchange verify changes reported or identified through data matching in accordance with the standards proposed in §155.315 and §155.320. Several commenters suggested that enrollees be given advance notice of changes identified through data matching and that they be able to affirm all changes prior to the Exchange using the new information. A number of commenters recommended that the notice proposed in §155.330(d) contain a right to appeal.

Response: For changes in eligibility identified by the Exchange through data matching, the procedures for notifying the enrollee should be more clearly outlined in the final rule. Therefore, in §155.330(e)(2) of this final rule we provide that for changes identified through data-matching that do not impact household income, family size, or family composition, the Exchange must notify the enrollee of the new data and his or her projected eligibility determination, and allow the enrollee 30 days to notify the Exchange if the information is inaccurate. If the enrollee responds that the information is inaccurate, the Exchange must proceed with the inconsistency process described in §155.315(f); if the enrollee responds that the information is accurate or does not respond, the Exchange must redetermine the enrollee's eligibility based on the verified data obtained through the data matching process.

For changes to household income, family size and family composition identified through data matching, we provide in §155.330(e)(3) of this final rule that the Exchange must notify the enrollee of the new data and his or her projected eligibility determination (including the amount of advance payments of the premium tax credit and the level of cost-sharing reductions), and allow the enrollee 30 days to respond to the notice. If the enrollee does respond confirming the

information obtained by the Exchange or responds by providing more up to date information, the Exchange must redetermine the enrollee's eligibility based on the data obtained through the data matching process or by verifying the updated information provided by the enrollee. However, if the enrollee does not respond, the Exchange must maintain the enrollee's eligibility without considering the new information. Because data related to income, family size and family composition has the potential to impact both the amount of financial assistance received by the enrollee and his or her tax liability at reconciliation, we believe the procedures for acting on such information should be different from the procedures for acting on data that do not have an impact on income and family size, and that enrollees must actively confirm such changes. We also note that the Exchange must notify the enrollee of the determination made as a result of a redetermination conducted during the benefit year, as indicated in (e)(1)(ii), and that such notice will include the right to appeal, in accordance with §155.355(a).

Comment: Several commenters suggested clarification of our policies related to effective dates, as proposed in §155.330(d). A number of commenters suggested that we align effective dates across part 155; among those suggestions was one to align the effective dates for redeterminations with effective dates for coverage under special enrollment periods, as described in §155.420. Further, we received comments which suggested that we establish a uniform cut-off date.

Response: We recognize the need for greater alignment between the effective dates for redeterminations of eligibility with effective dates for coverage, as described in §155.420 of this final rule. As such, in the final rule, we provide in §155.330(f) of this final rule that changes resulting from redeterminations during the benefit year must be implemented for the first day of the month following the date of the redetermination notice; however, we allow the Exchange to

establish a cut-off date after which redeterminations would be implemented in the following month, as long as the cut-off date is no earlier than the date established under §155.420(b)(1), (which is the 15th of the month) in order to effectuate coverage on the first of the following month. We believe that allowing the Exchange to establish such a cut-off date aligning with the cut-off date for coverage effective dates will facilitate administrative efficiency for the Exchange, if it chooses to align. Regarding comments requesting a uniform cut-off date, we wish to maintain Exchange flexibility to establish such a cut-off date, which is the same approach taken in subpart E, and so do not change the policy reflected in §155.330(f)(2) in this final rule. In the paragraph newly designated as §155.310(f) in this final rule, we also include the effective dates of eligibility for redeterminations, since these were inadvertently not included in the proposed rule. We also clarify that when we state that the effective date is the date on which the Exchange must implement an eligibility determination, we mean the date on which the applicant's eligibility, for example his or her advance payments of the premium tax credit or cost-sharing reduction, is or can be applied to the cost of his or her coverage.

Comment: We received a number of comments regarding the policy proposed in §155.330(e)(3), which provides that the Exchange must extend an enrollee's eligibility for enrollment in a QHP for a full month, without advance payments of the premium tax credit or cost-sharing reductions, following a notice of redetermination terminating his or her eligibility for enrollment. Several commenters expressed concern regarding this provision citing a potential for liability to issuers when enrollees neglected to or were unable to pay premiums without financial assistance. Some commenters suggested that individuals must pay premiums in order to receive such coverage, or that the redetermination notice clearly indicate when coverage will be terminated and that the enrollee will be liable for premiums not paid. Others

asked that we make clear that an enrollee may always choose to terminate his or her enrollment in a QHP sooner than the termination date included in paragraph (e)(3).

Response: We acknowledge commenters concerns regarding the potential for QHP liability during the available extension of coverage described in proposed §155.330(e)(3), redesignated as §155.330(f)(3). We will take into consideration such comments when developing the notice of eligibility determination sent to an enrollee when he or she loses advance payments of the premium tax credit after redetermination and ensure that an enrollee is aware of their responsibility to pay for his or her premium. Furthermore, the provision §155.430(d)(3) of this final rule, which allows the enrollee to maintain eligibility for enrollment in a QHP without advance payments or cost-sharing reductions until the last day of the month following the notice of termination of coverage is sent, also makes clear that an enrollee may terminate his or her enrollment sooner than such date. We also clarify that the final rule does not provide that an enrollee must pay a premium if he or she does terminate coverage sooner than the date described in §155.430(d)(3), but we acknowledge that this provision would not prevent an issuer from seeking out premiums owed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.330 of the proposed rule, with several modifications: we specified in paragraph (b)(1), that an enrollee must report any change with respect to the eligibility standard specified in §155.305 within 30 day of such change; however, we added in paragraph (b)(1) exceptions to this standard as described in new paragraphs (b)(2) and (b)(3). In new paragraph (b)(2), we provide that individuals who did request an eligibility determination for all insurance affordability programs must not be required to report changes related to eligibility for insurance affordability programs. In new paragraph (b)(3), we specified

that for changes in income, the Exchange may establish a reasonable threshold for such changes below which enrollees are not required to report. Also, in new paragraph (b)(4), we added that the Exchange must allow an enrollee, or an application filer on behalf of the enrollee, to report a change via all channels available for the submission of an application, which are described in §155.405(c).

We also created new paragraph (c), which describes the standards for the Exchange to verify changes reported by enrollees. We moved proposed paragraph (b)(2) and redesignated it as paragraph (c)(1) and added paragraph (c)(2), which describes that the Exchange must provide enrollees with periodic notifications regarding standards for reporting changes and the opportunity to report any change, to the extent the enrollee has elected to receive electronic notifications and has not opted out of periodic notifications regarding change reporting.

In new paragraph (d)(2), we added the opportunity for the Exchange to make additional efforts to identify and act on changes related to eligibility for insurance affordability programs, in addition to eligibility for enrollment in a QHP as previously proposed. We also removed the language that provided the Exchange with flexibility to conduct data matching during the benefit year, contingent upon HHS approval of a change to the Exchange Blueprint and instead included that this flexibility is subject to compliance with specific standards, including that such efforts 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 standards under §155.260, §155.270, §155.315(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. We also add that such efforts must comply with the newly designated paragraphs (e)(2) and (3).

In newly designated paragraph (e), we added paragraphs (e)(2) and (e)(3) to describe the procedures for redeterminations that Exchanges must follow upon identifying new information through data matching. In newly designated paragraph (e)(2), we specified that for all changes identified by the Exchange that are not related to income, family size and family composition, the Exchange must notify the enrollee of his or her projected eligibility determination and allow the enrollee 30 days from the date of the notice to inform the Exchange that such information is inaccurate. If the information is inaccurate, the Exchange must follow procedures related to resolving inconsistencies described in §155.315(f). If the enrollee does not respond within the 30 day period, the Exchange must redetermine his or her eligibility using the new information. In newly designated paragraph (e)(3), we specify that for changes identified by the Exchange that are related to income, family size and family composition, the Exchange must notify the enrollee of his or her projected eligibility determination and allow the enrollee 30 days from the date of the notice to respond to the notice. If the enrollee responds within the 30 day period, the Exchange must redetermine his or her eligibility in accordance with the procedures for redetermining enrollee-reported data. If the enrollee does not respond within the 30 day period, we specified that the Exchange must maintain the enrollee's eligibility determination without the updated information.

In newly designated paragraph (f), we amended the provisions related to effective dates for redeterminations made in accordance with this section. In newly designated paragraph (f)(1), we clarified the exceptions to the provision regarding effective dates for implementing changes resulting from a redetermination. In newly designated paragraph (f)(2), we added that while an Exchange may determine a reasonable point in a month after which a change captured through a redetermination will not be effective until the first day of the month after the month specified in

newly designated paragraph (f)(1). We clarify that such reasonable point must be no earlier than the cut-off date described in §155.420(b)(1) of this part. In newly designated paragraph (f)(3), we also added a new reference to the effective dates described in subpart E to accommodate for renumbering.

We renumbered several paragraphs in this section to accommodate changes to the final rule. Also, in paragraph (d), which was previously designated as paragraph (c), we changed the title to "periodic examination of data sources."

h. Annual eligibility redetermination (§155.335)

In §155.330, we proposed that the Exchange redetermine the eligibility of an enrollee in a QHP during a benefit year if it receives and verifies new information reported by an enrollee or identifies updated information through data matching. We solicited comments on whether the redetermination based on changes reported or identified during the year should satisfy the annual redetermination as well, and if so, whether this should be a Federal standard or an Exchange option. We also solicited comment on how the interaction between Exchange eligibility and updated tax data can be streamlined, and at what point annual redeterminations should occur. Finally, we solicited comment regarding whether and how we should approach data matching related to redeterminations, and whether there were alternatives that could support the goals of this process.

We also proposed that the Exchange provide an enrollee with an annual redetermination notice and identified specific data elements that should be contained in the notice and solicited comment regarding the contents of the notice. In addition, we proposed that the Exchange direct an individual to report any changes relative to the information listed on the redetermination notice within 30 days of the date of the notice, and specified that the Exchange must verify any

changes reported by the individual in response to the notice using the same verification procedures used at the point of initial application, including the provisions regarding inconsistencies.

We also proposed that an enrollee must sign and return the redetermination notice. We solicited comment on policy and operational strategies to improve the accuracy of redeterminations. We also solicited comment as to what steps the Exchange could take to ensure that redetermination minimizes burden on individuals, QHPs, and the Exchange without increasing inaccuracies.

After the conclusion of the 30 day notice period, we proposed that the Exchange determine an enrollee's eligibility based on the information provided to the enrollee in the redetermination notice, along with any information that an enrollee has provided in response to such notice that the Exchange has verified; notify the enrollee; and, if applicable, notify the enrollee's employer. If an enrollee does not sign and return the notice, we proposed that the Exchange redetermine an enrollee's eligibility based on the information provided in the notice. In addition, we proposed that to the extent that the Exchange is unable to verify a change reported by an enrollee as of the close of the 30 day period, the Exchange redetermine the enrollee's eligibility as soon as possible after completing verification.

We solicited comment as to whether the effective dates for changes made as a result of an annual redetermination should be different from the effective dates for changes made as a result of a redetermination that occurs during the coverage year.

Finally, we proposed that if an enrollee remains eligible for coverage in a QHP upon annual redetermination, the enrollee will remain in the QHP selected the previous year unless the enrollee takes action to select a new QHP or terminate coverage.

Comment: A number of commenters supported the provision in proposed §155.335(a) to conduct eligibility redeterminations on an annual basis. Many commenters highlighted that this would avoid administrative burden, costs, and loss of eligibility. Several commenters suggested that HHS not provide for more frequent redeterminations.

Response: In the final rule, we maintain the standard in §155.335(a) to redetermine eligibility on an annual basis. We address redeterminations during the coverage year in our responses to §155.330.

Comment: The majority of commenters recommended that the timing of annual redetermination as described in proposed §155.335 align with the annual open enrollment period as specified in §155.410. Some commenters suggested combining the annual open enrollment notice with the annual redetermination notice. Many commenters recommended that the annual redetermination notice be distributed prior to the start of the annual open enrollment period. One commenter suggested sending the annual redetermination notice no later than 45 days prior to annual open enrollment. Another commenter recommended that HHS provide that Exchanges must send annual redetermination notices to enrollees no later than June 15$^{th}$ of each year. Commenters also suggested giving Exchanges flexibility to determine the best way to conduct redeterminations.

Response: In response to the large number of comments we received on this topic, we have set a timing standard in §155.335(d) of this final rule for annual redetermination to align with annual open enrollment. In §155.335(d)(1), we provide that the Exchange must provide the annual redetermination notice and the notice of annual open enrollment in a single, coordinated notice for the 2015 and 2016 benefit year. We believe this will reduce confusion among consumers and reduce administrative burden. In §155.410(d), we specify that the notice of

annual open enrollment will be provided no earlier than September 1 and no later than September 30. We expect that as the program matures, States may have a better understanding of the best time to release the annual redetermination notice, and therefore in §155.335(d)(2) of this final rule, starting with annual redeterminations for coverage effective on January 1, 2017, we provide flexibility for Exchanges to adjust the timing and coordination of the redetermination notice in future years. The Exchange may exercise this flexibility to provide separate notices, provided that the timing of the redetermination notice is no earlier than the date of the notice of annual open enrollment specified in 155.410(d) and 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; this is to ensure that the enrollee has adequate time to review available plans and change plans, if applicable.

Comment: We solicited comment regarding whether a redetermination during the benefit year should satisfy the annual redetermination standard. Several commenters opposed this concept. One commenter recommended that allowing a redetermination of eligibility during the coverage year to serve as a household's annual redetermination should be a State option. Several commenters recommended that HHS should not give Exchanges the flexibility to conduct redeterminations on a rolling basis. Commenters suggested that annual redetermination should occur at a consistent point in the year for all individuals when new tax data becomes available, regardless if eligibility was redetermined during the coverage year.

Response: We decided not to allow redeterminations during the benefit year to satisfy the annual redetermination for an enrollee. Due to the fixed coverage period and a set annual open enrollment period, we believe allowing for a rolling annual redetermination would create a situation where the Exchange may redetermine an enrollee's eligibility but the enrollee would

not be able to switch plans because they would not qualify for an enrollment period. Additionally, we believe that because the annual redetermination relies on tax data which is updated at a specific time each year, rolling annual redetermination would add unnecessary complexity to the streamlined redetermination process. Finally, we also believe that this approach will increase the predictability of Exchange staffing and other resource needs.

Comment: Some commenters suggested HHS clarify that enrollees do not have to submit a new application to complete the annual redetermination process. Several commenters recommended that an individual's information from initial enrollment should be retained and used during the redetermination process. Accordingly, commenters suggested that an enrollee should never have to re-enter any information during the annual redetermination process that has not changed. A few commenters specified that States should use an "ex parte" redetermination process, in which the Exchange attempts to redetermine the enrollee's eligibility using information from external data sources; under such a process, the Exchange only contacts the enrollee if additional information is needed. Commenters also suggested that Exchanges and States should use a "passive" redetermination process, through which an enrollee notifies the Exchange that he or she agrees with the information included in a redetermination notice by not responding. Several commenters suggested that pre-populated forms or applications be used for annual redeterminations. Many commenters expressed support for the proactive role of the Exchange in obtaining data from external data sources to assist in annual redetermination.

Response: We have maintained the provisions in §155.335(c) of this final rule that outline information to be presented on the annual redetermination notice. We believe this will increase retention rates by helping to minimize the risk of individuals losing coverage when they remain eligible. We also believe this process will reduce administrative burden on the Exchange

by reducing the steps necessary to redetermine eligibility. Furthermore, we add language to paragraph (c)(3) providing that the notice of annual redetermination must include eligibility for Medicaid, CHIP or BHP, if applicable, since the updated tax return information and data regarding MAGI-based income may indicate eligibility for Medicaid, CHIP or BHP, in addition to eligibility for advance payments of the premium tax credit and cost-sharing reductions.

Comment: Several commenters recommended specific information for the content of the annual redetermination notice as specified in proposed §155.335(c). Items suggested include the date the redetermination will become effective, procedures to correct errors in data obtained or used in the enrollee's most recent eligibility determination, including the 30 day requirement to report changes specified in §155.335(e), or where individuals may obtain additional information or assistance, including the Exchange website, call center, Navigators and other consumer assistance tools. One commenter felt that notices regarding annual redeterminations may be confusing to many consumers. Some commenters recommended that notices comply with standards in §155.230 to ensure meaningful access for limited English proficient enrollees. Others recommended that annual redetermination notices include information about rights to appeal.

Response: We provide general standards for all notices from the Exchange in §155.230, which include accessibility and readability standards outlined in §155.205(b)(2) and (b)(3). We intend to provide further interpretation regarding issuance of the annual redetermination notice in future guidance which may include a model of the annual redetermination notice and detail on content.

In response to comments, we would also like to clarify the differences between the notices outlined in §155.335(c) and §155.310(g) of this final rule. The redetermination notice in

§155.335(c) is the pre-populated form which includes the enrollee's updated information, including —in the case of an enrollee who allowed the Exchange to determine his or her eligibility for insurance affordability programs— updated tax return information and updated current income information. In accordance with §155.335(e), this notice will be signed and returned by each enrollee to confirm information is up-to-date. After information on this notice has been verified and a final eligibility determination has been made, the Exchange will send a second notice described in §155.310(g), as finalized in this rule, to notify the enrollee of the final eligibility determination for the upcoming benefit year.

Comment: Many commenters recommended that the final rule should specify that enrollees can report changes through the same channels available for the submission of an application (online, by phone, by mail, in person), as specified in proposed §155.405.

Response: In 155.335(e)(2) of this final rule, we clarify that an enrollee or an application filer, on behalf of the enrollee, may report a change online, by phone, by mail, or in person. We identify these channels for an enrollee to provide additional information based on section 1413(b) of the Affordable Care Act and §155.405, which identify how an applicant may submit an application. As the annual redetermination will be functionally the same as a new application for the next benefit year, the use of the same procedures is appropriate. We have also added this provision to §155.330(b)(4), to allow an enrollee, or application filer on the enrollee's behalf, to report changes via the channels described in §155.405.

Comment: Some commenters supported the standard set forth in the proposed rule that the verification processes related to changes reported as a part of the annual redetermination process specified in proposed §155.335(e) be consistent with the processes specified in proposed §155.315 and §155.320. Many commenters suggested HHS specify timeframes by which the

Exchange must verify changes reported by the enrollee in response to the annual redetermination notice. One commenter suggested a time period of 10 days by which to conduct the verification. Another commenter believed States should have the flexibility to be able to determine any time constraints or verification processes related to changes reported in response to the annual redeterminations.

Response: We support the standard to use the same verification processes for initial applications and for annual redeterminations. We believe that the timeliness standards for verification should be consistent with the standards §155.310(e); we intend to provide more guidance on the interpretation of the timeliness standard.

Additionally, we would like to clarify that in order to conduct a redetermination as outlined in §155.335, the Exchange must obtain an authorization from an enrollee to request his or her tax data. We anticipate that this authorization will be obtained during the initial application process, and that such authorization could be accomplished, for example, by allowing enrollees a chance to opt out of authorizing the use of tax data. An enrollee must provide an authorization for the Exchange to obtain tax data for annual redeterminations only if he or she chooses to allow the Exchange to determine his or her eligibility for insurance affordability programs. We also clarify that without such authorization, the Exchange will be unable to access tax return information and, subsequently, conduct an eligibility redetermination for insurance affordability programs.

The Secretary of Treasury will allow an individual to authorize the release of his or her tax data for use by the Exchange in verification of household income for a period of up to five years. In 155.335(k), we specify that the Exchange must have authorization from an enrollee in order to obtain his or her updated tax return information for purposes of conducting an annual

redetermination. We specify that the Exchange may obtain this tax return information for a period of no more than five years, based on a single authorization. The Exchange must allow the individual to decline a five-year authorization or to authorize the Exchange to obtain tax return data for annual redetermination for a period of less than five years. We also specify that the Exchange must allow an individual to discontinue, change, or renew the authorization at any time. We expect that an enrollee will have an opportunity to reauthorize the Exchange to obtain tax return data whenever he or she reports changes, at annual redetermination, and in the course of other interactions with the Exchange. We believe this process will be minimally burdensome on the individual and on the Exchange.

In 155.335(l), we clarify that to the extent that an enrollee has requested an eligibility determination for all insurance affordability programs and has not authorized the request of tax data, the Exchange will redetermine the enrollee's eligibility for enrollment in a QHP, but must notify the enrollee that the Exchange will not proceed with the redetermination process until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability programs.

We also clarify that for purposes of providing updated data described in §155.335(b), we expect that the Exchange will obtain the updated information for enrollees who, as of their most recent interaction with the Exchange, has requested an eligibility determination for all insurance affordability programs; as such, for an enrollee who requested an eligibility determination for insurance affordability programs but who was determined ineligible for advance payments of the premium tax credits or cost-sharing reductions, the Exchange would obtain updated information at annual redetermination, to the extent that the applicable authorization was in place.

Comment: We received a large number of comments expressing concern over the

requirement for enrollees to sign and return the annual redetermination notice when no changes have occurred, as specified in proposed §155.335(f)(1). Commenters suggested the sign and return requirement was an unnecessary burden on consumers and Exchanges, since the Exchange is instructed to redetermine eligibility using the information on the notice even if the notice is not returned. A few commenters highlighted the current practice in Medicaid where annual redeterminations are completed without a signature required from the enrollee.

Response: While signing and returning the redetermination notice will add an additional step in the redetermination process, due to the financial responsibility imposed on an individual accepting an advance payment of the premium tax credit as part of the reconciliation process, we believe it is important to collect a signature from an enrollee as a means of ensuring that he or she accepts this responsibility.

Comment: Several commenters supported proposed §155.335(e), which provided that an enrollee correct any erroneous information on the redetermination notice and report changes to the information on the annual redetermination notice within 30 days. A few commenters urged HHS to consider extending the period enrollees are given to return the notice with reported changes consistent with the language in the Medicaid proposed rule, which provides States with the authority to increase this time period to more than 30 days.

Response: In the final rule, we maintain the standard of 30 days for an individual to report changes and believe this standard provides a reasonable amount of time for individuals to review the annual redetermination notice and submit changes as appropriate.

Comment: Commenters recommended adopting the effective dates outlined for the annual open enrollment periods in proposed §155.410(f) as the effective dates for annual redeterminations, except for enrollees who become eligible for Medicaid as a result of an annual

redetermination. In those cases, commenter recommended that Medicaid eligibility and coverage be effective on the first day of the month in which the eligibility determination is made.

Response: In §155.335(i) of the final rule, we have modified the language in the regulation text to clarify that the effective date for the annual redetermination will be the first day of the coverage year following the year in which the Exchange provided the annual redetermination notice in §155.335(c) or on the first day of the month following the eligibility notice to the enrollee in accordance with §155.330(f), whichever is later. The latter part of this clarification addresses situations in which the eligibility determination is made by the Exchange in the benefit year for which the applicant is seeking coverage. The effective dates for annual redetermination should not be confused with the dates by which the Exchange must make a QHP selection effective during the annual open enrollment period as specified in §155.410(f). Regarding commenters suggestions for the effective dates for individual determined eligible for Medicaid at annual redetermination, we clarify that coverage effective dates for Medicaid eligibility are governed by those standards found in Medicaid regulations at 42 CFR 435.915. In accordance with §155.310(d)(3), the Exchange must transmit enrollee information promptly and without undue delay to the State Medicaid or CHIP agency so that he or she may be enrolled in Medicaid or CHIP. We note that in accordance with section 36B(c)(2) of the Code, eligibility for premium tax credits (including the advance payments) and cost-sharing reductions will terminate when an individual is eligible for minimum essential coverage, including Medicaid and CHIP coverage.

Comment: Several commenters supported the provision specified in proposed §155.335(i) to allow an enrollee who remains eligible for enrollment in a QHP upon annual redetermination to remain in his or her QHP without the need to re-select it. One commenter

suggested the provision aligns with the goal of a simple and consumer-friendly Exchange. Another commenter emphasized that no enrollee should be removed from coverage until the enrollee has been given notice of an eligibility determination and the right to appeal.

Response: We are finalizing without change the provision to allow an enrollee who remains eligible for enrollment in a QHP upon annual redetermination to remain in his or her QHP without the need to re-select it. We believe this provision will minimize disruptions in coverage for eligible enrollees and administrative burden for the Exchange, QHP issuers, and enrollees. We also clarify that references to termination in this provision only relate to termination initiated by the enrollee, which we believe addresses the commenter's concern about notices and appeals.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.335 of the proposed rule, with the following modifications: in paragraph (a), we noted that annual redeterminations are limited based on the new language in paragraph (l) of this section. In paragraph (b), we clarified that in the case of an enrollee who has requested an eligibility determination for all insurance affordability programs in accordance with §155.310(b) of this subpart, the Exchange must request updated tax return information, if the enrollee has authorized the request of such tax return information. In paragraph (c), we added that the notice must also include an enrollee's projected eligibility determination, including eligibility for insurance affordability programs. In paragraph (d), we clarified the timing of the annual redetermination. For coverage effective January 1, 2015 and January 1, 2016, the Exchange must satisfy the notice provisions of paragraph (c) of this section and §155.410(d) of this part through a single, coordinated notice. In paragraph (d)(2), we provided that for coverage effective January 1, 2017, the Exchange may

send the annual redetermination notice separately from the notice of annual open enrollment, provided that certain restrictions on the timing of such notices are met.

In paragraph (e) of this section we clarified that the Exchange must allow an enrollee or an application filer, on the enrollee's behalf, to report changes via the channels available for the submission of an application, as described in §155.405(c) of this part. We also added to paragraph (g)(1), that an application filer may sign and return the annual redetermination notice on an enrollee's behalf. In paragraph (i), we modified the standard for effective dates of annual redetermination to clarify that the Exchange must ensure that the annual redetermination 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. In new paragraph (k), we added language to specify that the Exchange must have authorization from an enrollee in order to obtain updated tax return information for purposes of conducting an annual redetermination. We also describe that any single authorization will extend for a period of no more than five years, and that an individual may authorize the Exchange to obtain tax data for a period of less than five years, or not at all. We also provide that the enrollee must be able to discontinue, change or renew an authorization at any time. In new paragraph (l), we added language to specify that to the extent that an enrollee who has requested an eligibility determination for insurance affordability programs in accordance with §155.310(b) has not authorized the request of data described in paragraph (b), the Exchange must notify the enrollee in accordance with the timing described in paragraph (d), and not proceed with the redetermination process described in paragraphs (c) and (e) through (j) until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability

programs in accordance with §155.310(b).

We also made a few technical corrections to this section including renumbering paragraphs (d) through (k) to account for additional regulation text and updated cross-references based on similar renumbering in other parts of this final rule. In paragraph (e)(1) we clarified that the reference to a notice is referring to the notice in paragraph (c) of this section. We also clarified that changes reported at annual redetermination must be verified according to the processes specified in §155.315 and §155.320. Finally, we clarified that the verification referred to in paragraph (h)(2) of this section is the same verification specified in paragraph (f) of this section.

i. Administration of advance payments of the premium tax credit and cost-sharing reductions (§155.340)

In §155.340, we proposed reporting provisions for the Exchange related to advance payments of the premium tax credit and cost-sharing reductions. We proposed that in the event of a determination of an individual's eligibility or ineligibility for advance payments of the premium tax credit or cost-sharing reductions, including a change in the level of advance payments of the premium tax credit or cost-sharing reductions for which he or she is eligible, the Exchange provide information to the issuer of the QHP selected by the individual or in which the individual is enrolled.

We also proposed that the Exchange provide eligibility and enrollment information to HHS to enable HHS to begin, end, or adjust advance payments of the premium tax credit and cost-sharing reductions. We solicited comment on whether the information could be used by HHS to support any reporting necessary for monitoring, evaluation, and program integrity. We solicited comment as to how this interaction can work as smoothly as possible and the scope of

information that should be transmitted among the relevant agencies.

We further proposed that the information transmitted to issuers include the information necessary to enable the issuer of the QHP to implement or discontinue the implementation, or modify the level of an individual's advance payment of the premium tax credit or cost-sharing reductions.

We proposed to codify the reporting rules in sections 1311(d)(4)(I)(ii) through (iii) and 1311 (d)(4)(J), which support the employer responsibility provisions of the Affordable Care Act. We proposed that when the Exchange determines that an applicant is eligible to receive advance payments of the premium tax credit based in part on a finding that his or her employer does not provide minimum essential coverage, or provides minimum essential coverage that is unaffordable as described in 26 CFR 1.36B-2(c)(3)(v) of the Treasury proposed rule, or does not meet the minimum value standard, as described in 26 CFR 1.36B-2(c)(3)(vi) of the Treasury proposed rule, the Exchange will provide this information to the Secretary of the Treasury. We proposed that the Exchange transmit such applicant's name and SSN to HHS, which will transmit it to the Secretary of the Treasury.

In the event that 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, we proposed that the Exchange transmit the enrollee's name and SSN to HHS, which will transmit it to the Treasury. We also proposed that in the event an enrollee for whom advance payments of the premium tax credit are made or who is receiving cost-sharing reductions terminates coverage in a QHP through the Exchange during a benefit year, the Exchange transmit his or her name and SSN and the effective date of the termination of coverage to HHS, which will transmit it to the Treasury. We proposed that the Exchange will also transmit

his or her name and the effective date of the termination of coverage to his or her employer. Finally, we proposed that the Exchange must comply with the standards related to reconciliation of the advance payments of the premium tax credit specified in section 36B(f)(3) of the Code and 26 CFR 1.36B-5 regarding reporting to the IRS and to taxpayers.

Comment: We received a number of comments asking that we clarify how advance payments of the premium tax credit will be administered. Many comments suggested the use of electronic funds transfers, as well as electronic communications that are compatible with existing issuer infrastructure. Several commenters noted the importance of transparency and flexibility in establishing the standards regarding administration of the advance payment of the premium tax credit and cost-sharing reductions. Commenters suggested the need for further guidance on this topic.

Response: In §155.340 of this final rule, we provide general standards for the exchange of information necessary for administration of advance payments of the premium tax credit and cost-sharing reductions, as well as to support the employer responsibility and reconciliation provisions of the Affordable Care Act. We anticipate providing more operational and procedural detail about these processes in future guidance.

Comment: Several commenters recommended that the proposed §155.340(a) include a specific timeliness standard for the Exchange to transmit information to facilitate the administration of advance payments of the premium tax credit and cost-sharing reductions to the applicable QHP and HHS. Commenters recommended that the timeliness standard reflect the "real-time" expectation, but to provide for exceptions in instances when systems are not functioning properly. Some commenters suggested that the regulation specify that all transactions be completed within one business day from the initiating event (for example, the

completion of an eligibility determination).

Response: In paragraph (d), we adopt, on an interim final basis, a timeliness standard that the Exchange must perform actions outlined in §155.340(a) to enable advance payment of premium tax credits and cost-sharing reductions "promptly and without undue delay." We also adopt this standard for transmission of information described in §155.340(b). We intend to interpret this standard in future guidance.

Comment: Several commenters raised various privacy concerns in response to proposed §155.340(b)(2) and §155.340(b)(3)(i) prescribing that the Exchange transmit information to HHS when an enrollee changes employers and 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. Some commenters raised concerns over the amount of burden placed on Exchanges to provide this information to HHS and the Secretary of Treasury. A large number of commenters suggested that the information provided be limited to a minimum amount of information, only name and taxpayer ID number. Many commenters recommended striking, "Social Security number," and replacing it with, "taxpayer identification number."

Response: We codified the transactions specified in §155.340(b)(2) and §155.340(b)(3)(i) from section 1311(d)(4)(I) of the Affordable Care Act, which specifies that they include name and taxpayer identification number. Accordingly, we have replaced, "Social Security number," with "taxpayer identification number." We note that we have limited the information to be sent to HHS and to the Secretary of Treasury to be the information that is explicitly mentioned in section 1311(d)(4)(I). In addition, like all other activities related to personally identifiable information, the transactions specified in this section are subject to the privacy and security

protections specified in §155.260 of this final rule. Regarding concerns of burden on the Exchange, in addition to this being a statutory standard, we believe that this will largely be an automated process and that the submission of information to HHS and the Secretary of Treasury will not be overly burdensome.

Comment: A number of commenters sought more guidance on how cost-sharing reductions will be implemented and monitored. Commenters suggested HHS provide flexibility and transparency in establishing standards related to cost-sharing reductions.

Response: In §155.340 of this final rule, we specify that the Exchange will transmit information about an enrollee's eligibility to his or her QHP issuer in order to enable the QHP issuer to provide the correct level of cost-sharing reductions. We intend to provide future guidance on this issue and identify what we interpret to be the minimally necessary information for this purpose.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.340 of the proposed rule, with the following modifications: in §155.340(a) we replaced the terms applicant and enrollee with tax filer in connection with advance payments of premium tax credits because the tax filer is the eligible person for that benefit; we have retained the use of the terms applicant and enrollee in connection with cost-sharing reductions because that statute does not limit eligibility for that benefit to tax filers or tax payers. In §155.340(a)(2), we clarified that the Exchange must notify and transmit information necessary to enable the issuer of the QHP to implement, discontinue the implementation, or modify the level of an individual's advance payments of the premium tax credit or cost-sharing reductions, as applicable. In §155.340(b)(2) and (b)(3)(i) of this section, we removed the standard that the Exchange transmit the enrollee's SSN and replaced it with

taxpayer identification number. We also replaced the term "disenrolls" with "terminates coverage" to align with language used in §155.430 of this part. We note that coverage terminations by the Exchange are limited to enrollment through the Exchange. For a more detailed discussion, please see the comment and response for § 155.430. We also add in paragraph (d) a timeliness standard for the transmissions of information described in paragraphs (a) and (b).

j. Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-Existing Condition Insurance Plan (§155.345)

Based on comments and feedback to the proposed rule, we are revising the proposed rule to include paragraphs (a) and (g) of this section, and we are seeking comments on these provisions.

In §155.345, we proposed standards for coordination across insurance affordability programs in order to implement a streamlined, simplified system for eligibility determinations and enrollment as part of the implementation of section 1413 of the Affordable Care Act. In this section, we also proposed standards for coordination between the Exchange and the Pre-Existing Condition Insurance Plan (PCIP), established in accordance with section 1101 of the Affordable Care Act.

Specifically, we proposed that the Exchange enter into agreements with the State Medicaid or CHIP agencies as necessary to fulfill the Exchange responsibilities identified in this subpart. We proposed that as part of the eligibility determination process, the Exchange determine an applicant's eligibility for Medicaid and CHIP, in accordance with standards described in §155.305 of this subpart, notify the State agency administering Medicaid or CHIP of that determination, and transmit relevant information necessary for the timely enrollment of the

eligible individual into coverage. Upon making a determination of eligibility for Medicaid or CHIP, we indicated that the Exchange must also notify the applicant of the determination. We suggested that the Exchange may also facilitate delivery system and health plan selection for Medicaid and CHIP and solicited comments regarding whether and how this integration of delivery system selection could best work for the Exchange, Medicaid, and CHIP.

We also proposed that the Exchange perform a "screen and refer" function for those applicants who may be eligible for Medicaid in a MAGI-exempt category or an applicant that is potentially eligible for Medicaid based on factors not otherwise considered in this subpart. We proposed that the Exchange transmit eligibility information related to such application to the applicable State agencies promptly and without undue delay. In addition, we proposed that the Exchange provide advance payments of the premium tax credit and cost-sharing reductions to an individual who is found to be otherwise eligible while the agency administering Medicaid completes a more detailed determination.

We also noted, based on our interpretation of proposed Treasury §1.36B-2(c)(2) published on the same day in the Federal Register, that an applicant who is referred to the Medicaid agency for additional screening and is enrolled in a QHP receiving advance payments of the premium tax credit in the interim would not be liable to repay advance payments if he or she is ultimately determined eligible for Medicaid and for any period of retroactive eligibility.

We proposed that the Exchange provide an opportunity for an applicant who is not automatically referred to the State Medicaid agency for an eligibility determination to request a full screening of eligibility for Medicaid by such agency. We proposed that to the extent that an applicant requests such a determination, the Exchange will transmit the applicant's information to the State Medicaid agency promptly and without undue delay.

We also proposed that the Exchange work with the agencies administering Medicaid and CHIP to establish procedures through which an application that is submitted directly to an agency administering Medicaid or CHIP initiates an eligibility determination for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. In addition, we proposed that the Exchange utilize a secure, electronic interface for the exchange of data for the purpose of determining eligibility, including verifying whether an applicant requesting an eligibility determination for advance payments of the premium tax credit and cost-sharing reductions has been determined eligible for Medicaid or CHIP, and other functions specified under this subpart. We also proposed that the Exchange utilize any model agreements established by HHS for the purpose of sharing data as described in this section. We solicited comment as to the content of these model agreements.

Finally, we proposed to develop procedures for the transition of PCIP enrollees to coverage in QHPs offered through the Exchanges to ensure that PCIP enrollees do not experience a lapse in coverage. We solicited comment on additional responsibilities that should be assigned to an Exchange as part of this process, such as providing dedicated customer service staff for PCIP enrollees or actions that may accelerate or further streamline eligibility determinations for PCIP enrollees.

Comment: A large number of commenters supported a streamlined and coordinated eligibility determination process for all insurance affordability programs. A number of commenters also supported close alignment of policies between the Exchange and other insurance affordability programs to facilitate this streamlining and coordination. Commenters supported the standard specified in proposed §155.345(a) that the Exchange enter into agreements with Medicaid and CHIP agencies. A few commenters suggested that language be

added to regulation text to ensure that the Exchange eligibility determinations for Medicaid and CHIP comply with State plans and interpretive policies and procedures of the State agency or agencies administering the Medicaid or CHIP programs.

Response: We believe that agreements between the Exchange and other insurance affordability programs are important for ensuring such alignment and coordination across programs. We also note that in §155.300(b) of this final rule, we specify that, in general, references to Medicaid and CHIP regulations in this subpart refer to those regulations as implemented in accordance with policies and procedures as applied by the State Medicaid or State CHIP agency or as approved by the State Medicaid or State CHIP agency. With that said, we have also added new §155.302 in this final rule that describes in greater detail the options available for configuring responsibilities related to eligibility determinations, which clarifies that there is an option under which the Exchange does not make Medicaid or CHIP eligibility determinations but is considered to be compliant with this final rule; in such situations, the State Medicaid and CHIP agencies exercise final control over eligibility determinations for Medicaid and CHIP for applications submitted to the Exchange.

Additionally, we further clarify standards for coordination in §155.345(a) of this final rule to align with those outlined in the Medicaid final rule. Such standards are set to provide a clear delineation of responsibilities of each program to minimize burden on individuals, ensure prompt determinations of eligibility, enroll eligible individuals into the program promptly and without undue delay, and ensure compliance with the standards set forth in subpart D. We encourage States to work closely across the Exchange, Medicaid, and CHIP to simplify and streamline eligibility processes to maximize efficiency and minimize administrative costs.

In addition, in response to comments regarding coordinating policies across insurance affordability programs to avoid negative outcomes for consumers, we have added new 155.345(f), which provides a special rule for the limited number of situations in which a tax filer's household income, as defined in section 36B(d)(2) of the Code, is less than 100 percent of the FPL for the benefit year for which coverage is requested, the Exchange 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. This provision describes that the Exchange must provide information and explanation to the applicant and tax filer in such situations; we clarify that this language is new text, but that it is a means to address gaps in eligibility rules and procedures. This provision will only have an impact after the Medicaid rule in 42 CFR 435.603(i) is applied, which specifies that the Medicaid agency will determine Medicaid eligibility using section 36B rules, which should result in Medicaid eligibility in most cases. As such, we believe that the provision in paragraph (f) will be used in a very limited set of cases, but will ensure individuals are not affected by gaps in eligibility rules.

Comment: Several commenters highlighted the importance of coordinating eligibility and enrollment for individuals who are determined eligible for Medicaid based on factors other than MAGI, for example those qualifying based on disability status. Many commenters to the proposed rule expressed concern that the Exchange standards in proposed §155.345(b) through (d), which relate to those individuals potentially eligible for Medicaid based on factors not otherwise mentioned in this subpart were overly vague. Commenters requested that HHS provide further details and guidance on the "basic screening" standard specified in proposed paragraph §155.345(b)(1). Several commenters urged HHS to strengthen the standard and others

suggested the Exchange should ask a question or a set of questions to assess whether a person is eligible for Medicaid on a non-MAGI basis. Some commenters suggested striking a balance between gathering relevant information and not overburdening applicants with unnecessary questions. A few commenters suggested that States implement oversight mechanisms and protections to ensure that each applicant is directed to the most comprehensive benefits package to which he or she is entitled.

Response: We clarified that 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. We believe the term "screening" may have been misleading as the intention of the provision was to simply check the application for an indication that an applicant may be potentially eligible for Medicaid based on factors not otherwise considered, such as disability or age. We appreciate commenters' concerns that the Exchange only gather relevant information and not overburden applicants, and we believe that this approach will meet these standards.

Comment: Many commenters raised concerns that individuals may be unaware of coverage that may be available to them and suggested that HHS clarify how an individual who is not found eligible for Medicaid based on MAGI will be notified of the opportunity to request a full eligibility determination for Medicaid. One commenter suggested that we provide example scenarios in the final rule to show when an applicant may be determined ineligible in a screening but eligible after a full screening. Another commenter suggested the basic screening on factors other than MAGI could be confused as an eligibility determination. Some commenters suggested amending language in proposed §155.345(c) such that the Exchange must notify applicants of the Medicaid programs that may be available to them so the applicant can request an appropriate

determination of Medicaid eligibility from the State agency.

Response: To address this concern, in §155.345(b) of this final rule, we specify that the Exchange will 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 other than MAGI. While not every individual who is potentially eligible for Medicaid based on non-MAGI factors will be identified through the assessment in §155.345(b), we believe that this provision will help identify a substantial portion of those individuals.

We also clarify in §155.345(c) of this final rule that the Exchange will notify an applicant of his or her opportunity to request a full determination of eligibility for Medicaid and provide the applicant such opportunity. We anticipate that Exchanges will work with State Medicaid agencies to craft notice text that reflects the options available in specific States for Medicaid eligibility based on factors other than MAGI. We have added to paragraph §155.345(d) that the Exchange must notify the applicant during the application process that his or her application has been transmitted to the State Medicaid agency. We anticipate that such notices will be the subject of future guidance.

Comment: Many commenters highlighted the importance of seamless transmissions between coverage programs. Some commenters suggested clarifying, "promptly and without undue delay," and adding language providing that the Exchange must transmit the relevant information within 24 hours. A few commenters suggested that HHS establish standards for the State Medicaid agency to follow up on referrals it receives from the Exchange.

Response: We believe it would be more appropriate to interpret such a standard in guidance, which will allow it to evolve with technology and supporting business processes.

Comment: A few commenters also recommended aligning with Medicaid language to

clarify that relevant information transmitted to Medicaid or CHIP agencies includes the electronic account containing the finding of Medicaid or CHIP eligibility, all information provided on the application, and any information obtained or verified by the Exchange in making such a finding.

Response: We adopt the following standard to implement such a standard: the Exchange must transmit all information provided on the application and any information obtained or verified by, the Exchange to the State Medicaid agency. As discussed in more detail above, this Exchange final rule does not use the term "electronic account" but we believe that the scope of our standard appropriately aligns with the language in the Medicaid final rule on this point.

Comment: The majority of commenters supported the standard to provide advance payments of the premium tax credit to individuals seeking a determination of Medicaid eligibility on a basis other than MAGI until the State Medicaid agency notifies the Exchange that the applicant is eligible for Medicaid. Commenters highlighted that this standard encourages applicants to obtain the most comprehensive coverage for which they are eligible. Commenters also noted this standard is vital to ensuring that consumers have access to continuous health coverage while they navigate the eligibility and enrollment process in their State. One commenter recommended that applicants be able to waive enrollment in a QHP while awaiting a Medicaid/CHIP determination.

Response: We maintain this provision in the final rule. We clarify that this provision applies both when an applicant has not been determined eligible for Medicaid based on MAGI and either is referred by the Exchange to the State Medicaid agency based on screening, or requests a full Medicaid eligibility determination. We also clarify that an applicant is never required to enroll in a QHP while a full Medicaid determination is underway; the Exchange must

provide eligibility, but it is the choice of the applicant whether to actually select a QHP. We also clarify that this provision would apply only to the extent that the responsibility to conduct a determination for Medicaid eligibility on bases other than MAGI has not been delegated to the Exchange, through an agreement between the Exchange and the State Medicaid agency.

Comment: A few commenters said that the proposed process in §155.345(d) for applications submitted directly to Medicaid, CHIP, or BHP was vague and should be clarified to specify that such agencies will screen applicants to determine whether they are eligible for enrollment in a QHP with or without advance payments of the premium tax credit and cost-sharing reductions, and then "enroll" eligible applicants. Many commenters supported the provisions in proposed §155.345(d) that specified that an Exchange may not be required to duplicate any eligibility or verification findings that have already been made by agencies administering Medicaid, CHIP, or the BHP, where applicable. A few commenters suggested that language be added to clarify that Exchanges are not permitted, not simply "not required," to duplicate eligibility and verification findings made by the Medicaid or CHIP agency

Response: In §155.345(g) of this final rule, we clarify our intention to maintain a streamlined eligibility determination process for consumers. Consistent with the Medicaid final rule, we add standards for how agencies administering Medicaid, CHIP, and BHP will transmit an application to the Exchange and how the Exchange will take the necessary steps to process such applications. We note that the Medicaid final rule provides additional information regarding the responsibilities of the Medicaid agency with regards to applications submitted directly to Medicaid. In §155.345(g)(2), we clarify that the Exchange must not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart and in §155.345(g)(3). We also clarify that the Exchange

must not request information or documentation from the individual already provided to Medicaid, CHIP, or BHP that was included in the transmission to the Exchange. Additionally, in §155.345(g)(6) of this final rule, we specify that the Exchange must provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application. This provision is intended to ensure that an application that is submitted to a State Medicaid or CHIP agency follows the same processes for a complete MAGI-based determination of eligibility to enroll in a QHP, advance payments of the premium tax credit, and cost-sharing reductions.

Comment: Commenters supported the provisions in proposed §155.345(e) to use of a secure electronic interface to transmit data among the various agencies responsible for determining eligibility for the insurance affordability programs.

Response: We maintain these provisions in the final rule. In addition to these standards, we have also further specified standards for data sharing in §155.260 in this final rule. More information can be found in the responses to comments found in that section.

Comment: Several commenters requested guidance or standards in proposed §155.345(i) regarding the transition of Pre-existing Condition Insurance Plan (PCIP) enrollees into the Exchange, and many commenters provided specific suggestions as to what this guidance should consider. Some specific recommendations provided include that the Exchange should develop an agreement with PCIP; the Exchange and PCIP should coordinate to develop a letter informing PCIP enrollees of what they need to do to transition to the Exchange; customer service resources should be dedicated and trained to assist these enrollees to transition smoothly; and others provided recommendations regarding outreach, education, and information that should be provided to PCIP enrollees, frequently citing provider directories as an example of information

that needs to be clearly provided to PCIP enrollees. Some commenters recommended that information be transferred between the PCIP and Exchange programs to reduce the need for the Exchange to request duplicative information from PCIP enrollees and to ease their transition into the Exchange.

Several commenters emphasized that flexibility be given to States to accommodate the transition of PCIP enrollees due to concerns related to the influx of large numbers of high-risk people. Some of these commenters recommended that HHS consider allowing the Exchange to transition PCIP enrollees into 2014 and years beyond. One commenter recommended that the Federal government should not assign specific responsibilities to State-operated Exchanges relating to transitioning PCIP enrollees into Exchanges, while another commenter suggested that HHS evaluate mechanisms to ensure that a distribution of enrollees is balanced among QHPs in the Exchange.

Response: We will consider these comments as we develop future guidance to support a smooth transition of PCIP enrollees into the Exchange that minimizes disruption in the insurance marketplace to the greatest extent possible, while also ensuring that this population has access to affordable, high-quality health insurance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.345 of the proposed rule, with several modifications: in §155.345(a), we clarified that the Exchange must provide HHS with copies of any agreements made with other agencies administering insurance affordability programs upon request. We clarified that agreements must include a clear delineation of the responsibilities of each program to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment, including redeterminations, and ensure compliance with paragraphs (c), (d), (e), and

(g) of this section. We also modified language in §155.345(b) to specify that for an applicant who is not eligible for Medicaid based on the standards specified in §155.305 of this subpart, the Exchange must assess the information provided on the application to determine whether he or she is potentially eligible for Medicaid based on factors included in the streamlined application, but not otherwise considered in this subpart.

In §155.345(c) of this final rule, we added that the Exchange must provide, and notify an applicant of, the opportunity to request a full determination of eligibility for Medicaid. We also add that the Exchange must provide notification and opportunity for a full determination of eligibility for Medicaid when making a determination in accordance with §155.330 and §155. 335. We modified language in §155.345(d) to specify that if the Exchange identifies an applicant as potentially eligible for Medicaid or an applicant requests a full determination for Medicaid, the Exchange must 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.

In addition, we clarified language in §155.345(e) to provide that if an applicant potentially eligible for Medicaid is otherwise eligible for advance payments of the premium tax credit and cost-sharing reductions, the Exchange must provide the applicant with such advance payments of the premium tax credit or cost-sharing reductions until Medicaid notifies the Exchange that the applicant is eligible for Medicaid. We amended §155.345(f) to add a special rule to address situations in which a tax filer's household income is below 100 percent of the FPL for the benefit year for which coverage is requested, 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 is ineligible for Medicaid and CHIP based on income, in which case the Exchange

must provide the income information used in the Medicaid and CHIP determination to the applicant, and then repeat the verification process. We modified §155.345(g)(1) to include the standards set forth in the Medicaid final rule and outline that 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) not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart; (3) not request information or documentation from the individual already provided to another insurance affordability program; (4) promptly and without undue delay determine eligibility of the individual for enrollment in a QHP, advance payments of the premium tax credit and cost-sharing reductions, in accordance with this subpart; and (5) provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application. Additionally, we renumbered paragraphs (c) through (i) to account for the changes described above.

We also made two technical corrections. First, we amended the phrase "providing advance payments of the premium tax credit" to "providing eligibility for advance payments of the premium tax credit". Second, we changed, "Pre-Existing Condition Insurance Program" to "Pre-Existing Condition Insurance Plan" to match the actual name of the plan.

k. Special eligibility standards and process for Indians (§155.350)

In accordance with section 1402(d)(1) of the Affordable Care Act, in §155.350(a), we proposed that the Exchange determine eligibility for cost-sharing reductions for an applicant who is an Indian if he or she meets the standards related to eligibility for enrollment in a QHP and has

household income that does not exceed 300 percent of the FPL. We also proposed to clarify that the Exchange may only provide cost-sharing reductions to an individual who is an Indian if he or she is enrolled in a QHP. In addition, in §155.350(b) we provided that the Exchange must determine an applicant eligible for the special Indian cost-sharing rule in accordance with 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 that provides for collection or verification of income.

We further proposed a two-phase process by which the Exchange must verify an individual's attestation that he or she is an Indian for purposes of determining whether he or she qualifies for these cost-sharing rules. In paragraph (c)(1), we proposed that the Exchange must verify an applicant's attestation that he or she is an Indian if an applicant submits satisfactory documentation to support their attestation of citizenship or lawful presence in accordance with §155.315(e). In paragraph (c)(2), we proposed that the Exchange must rely on any available electronic data sources that have been authorized by HHS. Lastly, if the process under (c)(1) does not occur or data sources are unavailable, the individual is not represented in the source, or the source is not reasonably compatible with the applicant's attestation, we proposed that the Exchange follow the standard inconsistency procedures under §155.315(e). We solicited comment on the availability and usability of electronic data sources, as well as best practices for accepting and verifying documentation related to Indian status.

Comment: One commenter sought clarification about proposed §155.350(b), which codifies section 1402(d)(2) of the Affordable Care Act. The commenter noted that this section appears to apply only to those services received at the IHS, and the commenter asked if it also applies to referrals to outside specialists, etc. The commenter further suggested that the proposed regulations appear to go beyond what the statute asks and recommends that the special cost-

sharing provisions be limited to those services furnished through Indian Health Providers.

Response: Our intent is to adhere to the statute. In accordance with section 1402(d)(2) of the Affordable Care Act, the cost-sharing rule described in §155.350(b) of this final rule is limited to only to an item or service furnished directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services.

Comment: Several commenters generally requested that all applicants and potential applicants be given notice that there may be benefits and protections that apply if the applicant is an Indian. One commenter recommended that determining Indian status should be a one-time occurrence, and the commenter further requested that any data matching system used to identify eligible American Indians or Alaska Natives should only provide information essential to establish whether an individual is an Indian in order to protect the privacy of the individual from unwarranted intrusions. The commenter acknowledged that there will be cases in which further verification is necessary or where there is a gap in information available through data matching, and that there should be other vehicles by which an individual can establish qualifications for benefits and protections as an American Indian or Alaska Native. Another commenter suggested that any reasonable documentation be accepted, and lists a number of potential documents that would satisfy this policy. One commenter recommended that Indians with tribal enrollment cards should be able to submit their tribal enrollment number on their application.

Response: We anticipate that verification of Indian status for purposes of determining eligibility for Exchange-related benefits will only be a one-time occurrence for applicants. Additionally, the utilization of any electronic data sources for purposes of verification of Indian status will be subject to the privacy and security standards outlined in §155.260 and §155.270 of

this final rule, as is the case for all data acquired and used by the Exchange in the eligibility determination process. Lastly, under §155.350(c)(3) of this final rule, we reference section 1903(x)(3)(B)(v) of the Act for standards for acceptable documentation, which includes documents issued by Federally-recognized tribes. These standards for acceptable documentation provide uniformity in process for applicants claiming Indian status.

Comment: A few commenters recommended that the Exchange accept self-attestation for verification of Indian status, stating that self-attestation should be sufficient if the application questions are framed in a way that can be used to determine eligibility. One commenter suggested that verification of Indian status only be conducted when there are inconsistencies that cannot be resolved through simple explanation and attestation by the individual, or if there is some indication of fraud on the part of the individual, and further recommended that if electronic data sources are utilized to verify Indian status, that the only appropriate data source is the registration database used by Indian Tribe, Tribal Organization, or Urban Indian Organization programs.

Response: We are maintaining the verification process described under §155.350 in this final rule. This verification is tied to a full exemption from cost-sharing, which could involve a substantial expenditure for the Federal government; consequently, we are specifying a more stringent process for verification though we note that §155.315(h) allows the Exchange flexibility to modify this and other verification processes with HHS approval. In addition, we note that the documentation process described under §155.350(c)(3) is similar to the documentation process utilized by the IHS when determining eligibility for American Indians/Alaska Natives who seek services at IHS facilities. The standard for Exchanges is slightly different from the standard for such services, however, which means that the registration

database for Indian Tribe, Tribal Organization, or Urban Indian Organization programs may not be a one-to-one match. With that in mind, we are working closely with the IHS and intend to work with States and tribes to determine whether and how electronic data can support this process.

Comment: Several commenters recommended that American Indians be determined eligible for advance payments of the premium tax credit and cost-sharing reductions through the Exchange even if they have access to qualifying coverage in an eligible employer-sponsored plan, notably because cost-sharing may be more costly for the employer-sponsored plan in comparison to that for a QHP through the Exchange given the special cost-sharing benefits provided for Indians under section 1402(d) of the Affordable Care Act. Other commenters recommended that American Indians under 300 percent of the FPL should be exempt from both cost-sharing and premiums for QHPs through the Exchange.

Response: The comment regarding eligibility for advance payments of the premium tax credit and cost-sharing reductions based on eligibility for qualifying coverage in an eligible employer-sponsored plan is addressed in responses associated with §155.320(e). Additionally, in accordance with section 1302(c)(3) of the Affordable Care Act, the definition of "cost-sharing" as provided does not include premiums; therefore, HHS does not interpret this statutory provision to say that the special cost-sharing benefits provided to Indians under section 1402 of the Affordable Care Act includes an exemption from premiums for a QHP through the Exchange. Nothing in this final rule impacts an Indian's ability to access IHS facilities at no cost-sharing.

Summary of Regulatory Changes

For the reasons described in the proposed rule and considering the comments received, we

are finalizing the provisions proposed in §155.350 of the proposed rule, with the following modifications: in paragraph (a)(1)(i), we clarify that in accordance with section 1402(f)(2) of the Affordable Care Act, an applicant must be eligible for advance payments of the premium tax credit in order to receive cost-sharing reductions based in part on household income. In paragraph (a)(1)(ii), we add a citation to clarify that for purposes of cost-sharing reductions under paragraph (a)(1), household income is defined in section 36B(d)(2) of the Code and FPL is defined in section 36B(d)(3) of the Code.

l. Right to appeal (§155.355)

In §155.355, we proposed that an individual may appeal any eligibility determination or redetermination made by the Exchange, including determinations of eligibility for enrollment in a QHP, advance payments of the premium tax credit, and cost-sharing reductions. We noted that we intend to propose the details of the individual eligibility appeals processes, including standards for the Federal appeals process, in future rulemaking.

Comment: We received a number of comments in support of our proposal that the Exchange must provide a notice of the right to appeal and instructions on how to file an appeal of any aspect of an eligibility determination in accordance with proposed §155.310(g), §155.330(d), or §155.335(g). However, several commenters recommended that we provide greater detail around the appeals process in the final rule, including specific standards for the notice, coordination or integration with the Medicaid and CHIP appeals processes, and alignment of standards with Medicaid.

Response: We acknowledge the importance of providing greater detail regarding the appeals process, and will do so in future rulemaking.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.355 of the proposed rule, with the following technical modifications: in paragraph (a), we added "eligibility" to describe the determination notice. We also edited the references to other sections of subpart D to account for renumbering.

5. Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

In subpart E, we outline the initial, annual, and special enrollment periods as well as the enrollment process and the termination of coverage process.

a. Enrollment of qualified individuals into QHPs (§155.400).

In §155.400, we proposed that the Exchange must: (1) accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP; (2) notify the issuer of the applicant's selected QHP; and (3) transmit information necessary to enable the QHP issuer to enroll the applicant. We also proposed that the Exchange send QHP issuers enrollment information on a timely basis, and sought comment as to whether we should establish a specific frequency for enrollment transactions, such as in real time or daily, in our final rule. Finally, to ensure that the Exchange and QHP issuers have identical plan enrollment records, we proposed that the Exchange maintain records of enrollment, submit enrollment information to HHS, and reconcile the enrollment files with the QHP issuers no less than monthly.

Comment: With respect to proposed §155.400(a), several commenters recommended adding the limitation that the Exchange transmit "only" information necessary to effectuate enrollment. Commenters further recommended HHS identify the information that Exchanges should transmit to QHP issuers.

Response: We outline the limitations for information the Exchange may collect, use or receive in §155.260 of this final rule, which addresses privacy and security of information. Across all functions, the Exchange will only acquire, maintain, and disclose information that is necessary for Exchange operations. Specific data elements for transmission to QHP issuers will be identified at a later date.

Comment: One commenter recommended allowing Exchanges to contract with safety net providers to conduct enrollment activities, similar to the activities they perform for Medicaid.

Response: In general, the Exchange has discretion to contract with an eligible contracting entity to perform Exchange functions on its behalf, as outlined in §155.110 of this final rule. Furthermore, §155.210(c)(2)(viii) of this final rule allows for "other public or private entities that meet the standards of this section," to serve as Navigators, including "State or local human service agencies."

Comment: One commenter encouraged the Exchanges to initiate what it referred to as a preliminary "pipeline" reporting under proposed §155.400(a), so that QHP issuers would have a sense of the enrollment volume they might expect over the next month, particularly during, and leading up to open enrollment periods.

Response: Exchanges have the flexibility to notify QHP issuers of the number of individuals who have received eligibility determinations for coverage through the Exchange, as well as to work with QHP issuers to define other operational communications that would streamline administration. We do not believe it is necessary or within statutory authority for Exchanges to share any personally identifiable information with QHPs about individuals who have not selected the QHP issuer's offering.

Comment: Several commenters noted that the success of health reform hinges on individuals' ability to easily enroll in, and retain coverage. They generally recommended instituting enrollment processes that do not overburden individuals with paperwork and documentation.

Response: We believe the streamlined application discussed in §155.405 and the Internet Web site discussed in §155.205 of this final rule will help to achieve a streamlined process for all applicants. In addition, in §155.315(g) of this final rule, we codify a provision of the Affordable Care Act that specifies that an applicant does not have to provide information beyond the minimum necessary to support the eligibility and enrollment process.

Comment: One commenter recommended that QHP issuers be responsible for the enrollment of participants in the Exchange in accordance with proposed §155.400(a), since they currently facilitate the enrollment process, and will continue to do so for products outside of the Exchange.

Response: Prior to enrollment by the QHP issuer, the Exchange will need to transmit enrollment information to the QHP issuer because the individual must have an eligibility determination for coverage, and, if interested, for advance payments of the premium tax credit and cost-sharing reductions. Furthermore, the Exchange must report enrollment information to HHS in order to initiate advance payments of the premium tax credit and cost-sharing reductions. Once enrollment information has been provided by the Exchange, the QHP issuer is ultimately responsible for effectuating enrollment.

Comment: One commenter noted that the proposed provision in §155.400(a)(2) for the Exchange to transmit information necessary to enable the QHP issuer to enroll the applicant, appears to be inconsistent with the proposed §155.205(b)(6), now redesignated in this final rule

as §155.205(b)(5), which established that the Exchange Web site must have the capacity to allow enrollment. The commenter asked HHS to clarify whether these are intended as alternatives.

Response: We have clarified language in this final rule at §155.205(b)(5) to ensure that the Exchange Web site allows consumers to make a QHP selection, thereby initiating the enrollment process. Section 155.400(a)(2) of this final rule describes the subsequent step in the enrollment process, and establishes that Exchanges must transmit the QHP selection to the appropriate QHP issuer.

Comments: Many commenters requested clarification on the definition of a "timely" transmittal of enrollment information from the Exchange to QHP issuers, as discussed in proposed §155.400(b)(1). Some suggested specifying "daily," "real-time," or leaving the definition to State flexibility.

Response: In this final rule, we have modified the regulatory text in §155.400(b)(1) to be consistent §155.340(d), which states that Exchanges must send eligibility information to both QHP issuers and to HHS promptly and without undue delay. We expect Exchanges will send each QHP issuer an automated file of applicable eligibility and enrollment transactions, and simply include HHS on the transmission. HHS will issue future guidance outlining standards and timing for these transmissions. We further expect Exchanges to use the monthly reconciliation standards outlined in §155.400(c) and §155.400(d) to ensure consistency in enrollment records.

Comment: A few health insurance issuers cautioned that the QHP issuer's acknowledgement of the receipt of an enrollment transaction under proposed §155.400(b)(2) is not a confirmation that the information is complete. The commenters stated that it should be the responsibility of the Exchange to ensure that the eligibility and enrollment information being sent to the QHP issuer is complete and accurate. One commenter recommended a strong file validation protocol, so that any incomplete or conflicting records were identified prior to submission.

Response: The intent of the acknowledgement standard in §155.400(b)(2) is to ensure that QHP issuers accept responsibility for completing an individual's enrollment. We expect Exchanges will establish a process by which the QHP issuer signifies that it has received complete and accurate enrollment information, and if it does not, promptly notifies the Exchange that the information is insufficient to complete enrollment.

Comment: One commenter recommended that QHP issuers acknowledge the receipt of eligibility and enrollment information, as described in proposed §155.400(b)(2), to both the Exchange and the applicant, while one health insurance issuer recommended that State laws govern communication between QHP issuers and enrollees.

Response: We clarify in part 156 the information that QHP issuers must provide to enrollees. As finalized in §156.260(b), the QHP issuer must provide notice of the effective date of coverage and must provide new enrollees an enrollment information package as an acknowledgement of enrollment as described in §156.265(e). However, we note that Exchanges may apply additional rules to ensure an optimal consumer experience, such as notifying the applicant that the Exchange has transmitted enrollment information to the QHP issuer.

Comments: Several commenters requested clarification on reporting standards under proposed §155.400(c), including timing, format, and content. Some commenters requested that the HHS reporting standard be omitted. One State agency recommended that State regulators have unfettered access to all data sets used for and by Exchanges.

Response: As noted above, HHS plans to provide guidance on timing, format, and content of the enrollment information transmissions required under §155.400 of this final rule. We have removed the standard in proposed §155.400(c) for Exchanges to submit enrollment information to HHS on a monthly basis, because §155.400(b)(2) of this final rule directs

Exchanges to send eligibility and enrollment information to HHS "promptly and without undue delay." With respect to the comment on the ability of State regulators to have access to all data collected and used by Exchanges, we note that data sets that contain personally identifiable information, and that are used by an Exchange while the Exchange is fulfilling its responsibilities in accordance with §155.200(c), may only be disclosed if such disclosure is consistent with §155.260. Disclosures for other purposes must be consistent with applicable Federal and State laws.

Comment: For the reporting and reconciliation standards outlined in proposed §155.400(c) and §155.400(d), one commenter requested clarification to ensure that Exchanges may collect monthly enrollment and termination data directly from insurers. The commenter sought to eliminate the need for the Exchange to collect this information on a case by case basis, compile it, and then reconcile it with issuers; all activities that the commenter stated are not feasible under a free market model where the Exchange Web site may not be tracking individual's coverage choices.

Response: Per subpart D of both the proposed and final rules, the Exchange must make a determination of an individual's eligibility in order for a person to enroll in a QHP through the Exchange. In addition, per §155.340(a), the Exchange must know which QHP a qualified individual has selected in order to make any advance payments of the premium tax credit. We do not believe that collection of enrollment data from issuers on a monthly basis would be sufficient to meet these standards, and therefore maintain the policy in §155.400 of this final rule.

Comment: Most commenters supported a minimum monthly reconciliation under §155.400(d), as long as Exchanges retained flexibility to reconcile more frequently. One health

insurance issuer recommended reconciling only the cases with changes on a more frequent basis, while reconciling the full case load on a quarterly basis.

Response: In this final rule, we maintain the requirement in §155.400(d) for monthly reconciliation, and require Exchanges to reconcile enrollment information with HHS in addition to QHP issuers. Exchanges have flexibility to reconcile some or all cases more frequently. We expect that Exchanges will work to minimize enrollment discrepancies, to automate reconciliation where possible, and to streamline any manual reconciliation activities that remain necessary.

Summary of Regulatory Changes

We are finalizing the standards proposed in §155.400 of the proposed rule with the following modifications: in §155.400(b) regarding the timing of data exchanges, we specify in the final rule that the Exchange must send enrollment information to both QHP issuers and HHS promptly and without undue delay. In §155.400(c) we remove the standard that Exchanges submit enrollment information to HHS on a monthly basis. In §155.400(d), we establish that Exchanges must reconcile enrollment information with both QHP issuers and HHS no less than on a monthly basis. We also made a few non-substantive edits to streamline the regulatory text.

b. Single streamlined application (§155.405)

In §155.405, we proposed to codify that a QHP issuer must use the single streamlined application for qualified individuals and employers to enroll in QHPs through the Exchange. We also offered States the option to develop an alternative application, subject to approval by HHS. We sought comment regarding whether we should establish that applicants do not have to answer questions that are not pertinent to the eligibility and enrollment process.

We further proposed that the Exchange must accept applications from multiple sources

including the applicant, an authorized representative (as defined by State law), or someone acting responsibly for the applicant; and that an individual must be able to file an application online, by telephone, by mail, or in person. We solicited comment on whether an individual must be able to file an application in person.

Comment: A handful of commenters urged that the application described in proposed §155.405(a) enable eligibility determinations for other human services programs such as the Supplemental Nutritional Assistance Program (SNAP) and Temporary Assistance for Needy Families (TANF) in addition to Medicaid, CHIP, and BHP.

Response: In this final rule, we are only establishing that the application support eligibility for Exchange coverage and insurance affordability programs. With that said, States can decide to use HHS-approved alternative applications that include human services programs.

Comment: Some commenters suggested that all States should use the HHS-created application and requested that we strike proposed §155.405(b) from this section, which pertains to alternative applications. Issuers were concerned that they could be subjected to too much variation in Exchange applications. Other commenters supported our proposal to give States flexibility to create an alternative application should they desire.

Response: Section 1413(b)(1)(B) of the Affordable Care Act directs HHS to allow a State to develop and use its application, subject to compliance with standards. We do not believe that variations in applications will place a burden on QHP issuers since the necessary enrollment information will be consistent across Exchanges. In addition, we reiterate our position in the proposed rule that the single streamlined application has been developed to meet the requirement for a uniform enrollment form, as set forth in section 1311(c)(1)(F) of the Affordable Care Act. We further clarify that the single streamlined application, or an HHS-approved Exchange

alternative application, must be used for enrollment in a QHP through the Exchange only. Per §156.265 of the final rule, a QHP can satisfy the standard regarding use of the single streamlined application by directing the individual to file the single streamlined application with the Exchange, or ensuring the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

Comment: Numerous commenters urged HHS to add language to proposed §155.405 stating that the standard single streamlined application should not include questions that are not pertinent to the eligibility and enrollment process. Other commenters wanted to ensure that the application will collect demographic information beyond what is established in the statute.

Response: The Exchange eligibility proposed rule and this final rule at §155.315(g) prohibit Exchanges from requiring information beyond the minimum necessary to support eligibility determinations for the Exchange and insurance affordability programs. This provision limits the application to information that is pertinent to the eligibility and enrollment process.

Comment: Numerous commenters expressed support for allowing an applicant to file an application in person, as described in the preamble to §155.405 in the proposed rule. A handful of commenters also urged HHS to go further and establish that Exchanges must allow individuals to submit, change, or renew coverage at numerous locations, including social service offices, welfare offices, community-based organizations, and any other pathway that accepts applications for government health benefit programs. Some commenters expressed concern that the proposed regulation did not ensure effective communication for individuals with disabilities because it did not provide for assistance when filing an application in person. Other commenters suggested that HHS establish that Exchanges must provide in-person assistance in a number of different locations throughout States.

Response: We are maintaining the standard that applicants should be able to file an application for an eligibility determination through the Exchange and other insurance affordability programs in person. We have added to regulation text in §155.405(c)(2)(iv) to establish that the facilities where someone files an application in person comply with the Americans with Disabilities Act. However, Exchanges have the flexibility to determine the venues at which applicants may file in person, which will allow Exchanges to configure staffing to meet the specific characteristics of each State. We encourage Exchanges to consider allowing enrollees to submit changes or complete the annual redetermination process at an in-person location. We are not, however, amending this in the final rule.

Comment: A handful of commenters suggested that an Exchange could fulfill the standard to accept applications in person in accordance with proposed §155.405(c)(2) through its Navigator program. These commenters stated that in-person assistance may be burdensome for the States, but Navigators are a natural venue for such assistance.

Response: An Exchange has flexibility in how it structures it Navigator program and may use such a program to meet the standard for in-person application filing and to provide assistance to individuals applying for coverage through the Exchange.

Comment: Some commenters requested that the application provide meaningful access for individuals who are LEP, provide effective communication for individuals with disabilities, and also that the application be translated into a number of different languages. Some commenters recommended the application be translated into no fewer than 15 languages.

Response: We address meaningful access issues and concerns in §155.205(c) as well as in §155.230(b) of this final rule. Additional guidance issued at a later date will coordinate our accessibility standards with insurance affordability programs, and across HHS programs, as

appropriate, providing more detail regarding literacy levels, language services and access standards.

Comment: A significant number of commenters asked for clarification on who can qualify as an authorized representative to file an application on behalf of an applicant under proposed §155.405(c)(1) and, in particular, on what HHS meant by "someone acting responsibly for the applicant" and how this role is different from an authorized representative. Other commenters asked for more details on the privacy standards that will be applied to authorized representatives and others assisting with the application process. Additionally, commenters thought that the final rule should specify that a Navigator cannot apply on behalf of the individual without the signed consent of an individual or an individual's parent, guardian, court-designated representative or legally-approved family member.

Response: We expect to provide future guidance regarding who may serve as an authorized representative; we intend for this to track against who can serve as an authorized representative under Medicaid. We also note that a single application may have both an application filer and an authorized representative. In paragraph §155.405(c) of this final rule, we state that an "application filer" may file the application, and we have added a corresponding definition in §155.20 in this final rule that notes that an application filer includes authorized representatives as well as someone acting responsibly for the applicant, if the applicant is a minor or incapacitated. This change clarifies situations when someone acting responsibly for the applicant might file an application. In addition, the privacy and security standards addressed in §155.260 apply to any person or entity that views or receives personally identifiable information from or on behalf of an applicant through the Exchange. Therefore, we believe that these standards will ensure appropriate privacy standards for authorized representatives and others

assisting applicants. Further, the application process will include an authentication process. HHS expects to issue future guidance on the authentication process to verify an individual's identity. In addition, we expect that application assisters who are not Navigators, agents, or brokers will provide support for consumers during the application process, and we anticipate providing additional guidance regarding this role, including on appropriate privacy and security protections.

Comment: Several commenters asked for clarification regarding whether mobile devices could be used to apply for coverage under proposed §155.405(c)(2). Many of these commenters recommended that the final rule establish that the single streamlined application must be available through mobile devices or mobile applications.

Response: In this final rule, Exchanges must only provide an online application at this time (see §155.405(c)(2)(i)). Although it may be beneficial for applicants to be able to complete the application and the plan selection process using a mobile device, Exchanges do not have to provide this functionality given the short implementation timeframe.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.405 of the proposed rule, with a few small modifications: we changed final rule in §155.405(b) from "request" to "collect" for consistency with other parts of the final rule. We replaced (c)(1)(i) through (c)(1)(iii) of the proposed rule with (c)(1) "application filer," which incorporates the previous categories included in the proposed rule. In paragraph (c)(2), we have made minor clarifying edits. We codified the standard that an individual may file an application for coverage in person and clarified that reasonable accommodations must be made for individuals with disabilities.

c. Initial and annual open enrollment periods (§155.410)

In §155.410, we proposed that the Exchange adhere to specified initial and annual open enrollment periods and indicated that qualified individuals and enrollees may begin or change coverage in a QHP at such times. We sought comment on the duration of the initial open enrollment period, which we proposed to be from October 1, 2013 to February 28, 2014. We also requested comment on the proposed annual open enrollment period (October 15 to December 7 of each year) and whether we should consider an alternative annual enrollment period from November 1 through December 15 of each year.

We also proposed standards for effective dates based on the date when an individual's QHP selection is received. To coordinate coverage in a QHP with the advance payments of the premium tax credit, we proposed that coverage in a QHP may only begin on the first of the month. We sought comment as to whether we should consider twice monthly or flexible effective dates of coverage for individuals who forgo advance payment of the premium tax credit for the first partial month or who are not eligible for advance payments of the premium tax credit.

We also proposed that the Exchange must send written notification to enrollees about the annual open enrollment period and sought comment on whether we should codify specific elements that must be included in the notification and timing of the notification. We further proposed that the Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

Finally, we sought comment on whether Exchanges should automatically enroll individuals who received advance payments of the premium tax credit and then have coverage terminated from a QHP because the QHP is no longer offered, if such individual does not make a

new QHP selection. We also sought comment on whether we should allow for automatic enrollment of individuals in specific circumstances, such as mergers between issuers or when one QHP offered through a specific issuer is no longer offered, but there are other options available to the individual through the same issuer. Lastly, we sought comment as to how far such automatic enrollment should extend if we were to allow it.

Comment: Several commenters expressed concern about adverse selection with respect to the enrollment periods in proposed §155.410 and §155.420. The commenters supported limited enrollment periods and opposed any flexibility for States to implement longer or more frequent enrollment periods.

Response: In both the proposed and final rules, we have attempted to balance the risk of adverse selection with the need to ensure that consumers have adequate opportunity to enroll in QHPs through an Exchange. We believe that the enrollment periods described in §155.410 and §155.420 of this final rule achieve that balance. As we describe later in this section, we believe that additional time is needed for the initial enrollment period, given that Exchanges are a new coverage option under the Affordable Care Act, and significant education and outreach will be needed to make individuals aware of this coverage opportunity.

Comment: Several commenters requested more State flexibility with respect to the enrollment periods identified under proposed §155.410 and §155.420. The commenters recommended States have flexibility to set their own enrollment periods and effective dates, especially those States already operating Exchanges. A few commenters requested State flexibility to extend enrollment periods, particularly for vulnerable populations.

Response: Section 1311(c)(6) of the Affordable Care Act specifically directs the Secretary to provide for initial, annual and special enrollment periods. In both the proposed and

final rule, we have tried to provide State flexibility while adhering to our responsibility under the statute to establish the enrollment periods identified under section 1311(c). Therefore, we have proposed and finalized in this rule the minimum uniform enrollment periods across all Exchanges, including a special enrollment period for individuals experiencing an exceptional circumstance.

Comment: Almost all commenters supported the proposed start date of October 1, 2013 under proposed §155.410(b) for the initial open enrollment period. One State agency believed it was unrealistic to expect Exchanges to be operational prior to January 1, 2014, given the systems development challenges ahead. A few commenters requested flexibility to begin enrollment, or a "pre-qualification" period before October 1, 2013. Commenters recommended an initial open enrollment period lasting as few as two months and as long as three years. The majority of commenters recommended a six-month initial open enrollment period, ending on March 31, 2014, one month later than in the proposed rule. Most commenters suggested that the longer initial open enrollment period would allow more time for individuals and families to learn about their coverage options, and more time for them to select a QHP. Finally, commenters recommended that individuals who enroll during the initial open enrollment period be permitted to change plans at least once without penalty during the Exchanges' first year of operation.

Response: In this final rule, we maintain the start date of October 1, 2013 for the start of the initial open enrollment period. Although coverage will not be effective until January 1, 2014, we believe that individuals and families need time to explore their coverage options and QHPs need time to process plan selections. We have extended the initial open enrollment period by one month – from February 28, 2014 to March 31, 2014. HHS's experience with the initial open enrollment period for Medicare's Prescription Drug Benefit Program supports an extended

period. We have not extended the initial open enrollment period past March 31 in order to limit the risk of adverse selection, as expressed by commenters.

Comment: Several commenters recommended a robust outreach campaign prior to the initial open enrollment period. One group recommended that health insurance issuers notify all individual market subscribers about their potential eligibility for financial assistance through an Exchange under this section.

Response: We encourage Exchanges to leverage existing resources in their marketing efforts, including working with issuers to determine how they can participate most effectively. Section 155.205(e) of this final rule directs Exchanges to conduct outreach and education activities to educate consumers about the Exchange and to encourage participation.

Comments: Several commenters representing State agencies and health insurance issuers expressed concern about effective dates proposed in §155.410(c). The commenters asserted that the specified minimum of eight days between plan selection and coverage effective date was too short, and that they needed as many as 30 days to make coverage effective. Commenters recommended that we ensure there is sufficient lag time between QHP selection and effective dates.

Response: Based on the commenters' recommendation to allow more time between QHP selection and effective dates, we have modified the proposed QHP selection cutoff date in this final rule from the 22nd to the 15th of the month. As described in more detail below, we have also provided flexibility for Exchanges to work with QHP issuers to make coverage effective more quickly.

Comment: Many commenters, namely consumer and patient advocates, were concerned that the proposed effective dates under §155.410(c) and §155.410(f) would lead to coverage gaps

for individuals losing coverage mid-month. The commenters offered alternative effective dates, including twice monthly, continuous, and retroactive. Many commenters responded positively to our solicitation for comments on whether to allow mid-month or flexible effective dates for qualified individuals willing to forgo advance payments of the premium tax credit until the 1st of the following month, or who are ineligible for such payments. Others requested that coverage be guaranteed for the 1st of the month for all qualified individuals, even when they select a QHP on the last day of the previous month. Finally, a few commenters recommended printable, temporary insurance cards that individuals could use until the enrollment process was completed.

Response: We recognize the need to minimize coverage gaps, especially for vulnerable populations. However, the suggested alternatives could have negative consequences for Exchanges and QHP issuers, by increasing costs and administrative burden. Because the initial open enrollment period will be the Exchanges' first experience with enrollment, and many newly-eligible individuals will be seeking to enroll at the same time, we believe it is important to maintain administrative processes consistent with health insurance issuers' experience, while at the same time including flexibility for improvement as Exchanges and QHP issuers enhance their capabilities.

In response to commenters' concerns, we have added two new options for earlier initial open enrollment period effective dates in §155.410(c)(2) of this final rule. We have also added the same options for special enrollment period effective dates in §155.420(b)(3) of this final rule. An Exchange may adopt one or both options, provided that it demonstrate to HHS that all of the participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in §155.410(c)(1)(ii) through §155.410(c)(1)(iii). We include this qualification because QHP issuers may need to implement administrative changes to accommodate the modified effective

dates. We note that individuals seeking the earlier effective date described in §155.410(c)(2)(i)(B) must waive the benefit of advance payments of the premium tax credit and cost-sharing reductions if coverage is effectuated mid-month. However, individuals do not have to accept this earlier effective date. As an example, if all QHP issuers in State X agree that they can effectuate coverage eight days after QHP selection, and individual A makes a QHP selection on January 17th, 2014, the issuer may effectuate the coverage on January 25th, provided that the individual is willing to forgo advance payment of the premium tax credit for the seven days of coverage in January.

Comment: In response to our request for comment in the preamble of proposed §155.410(d) on whether we should set a standard for the timing of the annual open enrollment notice, most commenters supported a standard for the Exchange to send a notice of annual open enrollment 30 days prior to the start of enrollment, though one patient advocacy organization recommended 60 days' notice.

Response: We have added a standard in this final rule in §155.410(d) that the Exchange send the notice no earlier than September 1st, and no later than September 30th of each year, in preparation for an October 15th annual open enrollment. Because subpart D of this final rule directs the annual redetermination notice to be combined with the annual open enrollment notice, we have allowed a 30 day window for States to produce and mail the combined notice. We believe that 60 days is too far in advance of annual open enrollment for enrollees to remember to take action.

Comment: Many commenters representing patient and consumer advocacy groups recommended that proposed §155.410(d) establish an additional notice to be sent 30 days before the end of the annual open enrollment period to enrollees who had not yet selected a QHP. Some

commenters recommended the use of social media and mass media to increase awareness of annual open enrollment.

Response: We note that Exchanges may send additional notices and conduct outreach to assist consumers with enrollment, but we do not establish such notices as a minimum standard.

Comment: A few commenters recommended that HHS provide a model annual open enrollment notice and a process for deviating from that notice. Suggestions for the notice's content included: meaningful access standards, information about how to access brokers and application assisters, an explanation of the once-a-year nature of an annual enrollment period, the implications of going uninsured, and the criteria for qualifying for a special enrollment period. Several commenters recommended that the notice of annual eligibility redetermination described in proposed §155.335(c) be combined with the notice of annual open enrollment described in §155.410(d), into a single, streamlined notice.

Response: HHS intends to provide Exchanges with a model notice in future guidance. The model will consider the content recommended above. In response to commenters' recommendation to combine and streamline notices, we have added timing standards to the notice of annual redetermination notice in §155.335(d) of this final rule.

Comment: One commenter noted that health insurance issuers already send a notice of annual open enrollment. The commenter stated that if Exchanges did the same, as described in proposed §155.410(d), it would be duplicative and unnecessarily burdensome for Exchanges.

Response: While it is possible that an Exchange or a State insurance regulator might direct health insurance issuers to send a notice of annual open enrollment, HHS is not imposing such a standard. We therefore do not believe §155.410(d) is duplicative, and we maintain it in the final rule. Issuers may continue to send such notices at their discretion.

Comment: Several commenters, namely health insurance issuers, recommended a shorter annual open enrollment period under proposed §155.410(e), lasting between 30 and 45 days, to discourage adverse selection. Conversely, several other commenters recommend extending the annual open enrollment period until at least December 15th (for a total of at least 60 days), to give individuals and families more time to explore their coverage options. One commenter recommended quarterly instead of annual open enrollment periods, to increase opportunities for consumers to enroll. Commenters recommended annual open enrollment periods lasting between 30 and 90 days, with several recommending continuous open enrollment.

Response: As noted above, the rule seeks to balance flexibility for consumers with the need to limit adverse selection. The 53-day length of the annual open enrollment period balances these competing interests, and gives individuals and families ample time to explore coverage options. Therefore we maintain the annual open enrollment start and end dates in §155.410(e) of this final rule.

Comment: One health insurance issuer suggested limiting an enrollee's QHP selection during annual open enrollment in proposed §155.410(e) to only one metal level higher. For example, the commenter believed that enrollees should not be permitted to move from a bronze level QHP to a gold or platinum level QHP. In response to a similar proposal in §155.420(f) of the proposed rule to limit movement between QHPs during special enrollment periods, most commenters, with the exception of a few health insurance issuers, either objected to the provision outright, or recommended additional exceptions to allow movement between QHPs. One commenter noted that because the special enrollment periods were generally not tied to changes in an individual's health status, they did not pose a risk of adverse selection.

Response: We have removed §155.420(f) from the final rule. We do not believe it is

appropriate to limit enrollee movement between QHPs during the annual open enrollment period in §155.410(e), and we have not added the restriction requested by the commenter.

Comment: With respect to the proposed annual open enrollment period under §155.410(e), many commenters were concerned that its overlap with the open enrollment periods for SHOP, Medicare and other Federal programs would create an unmanageable administrative workload at the end of each year. Some commenters suggested moving the Exchange's open enrollment until after the first of the year to better align it with tax filing season and with many employers' annual open enrollment periods. Others recommended staggered, individual-specific open enrollment periods. For example, periods could be linked to birthdays, to spread out enrollment over the course of the year. Others recommended that the annual open enrollment period reflect the current enrollment practices in the individual and small-group market, and at the least, align inside and outside the Exchange. Some commenters representing senior citizens supported the alignment with Medicare.

Response: We recognize that the annual open enrollment period overlaps with that of other Federal programs. However, we believe that the alternatives suggested by commenters would lead to undesirable outcomes. For instance, aligning the annual open enrollment period with the tax season would mean that the coverage year and the tax year no longer align, and in the first year consumers could have more than 12 months of coverage before receiving an opportunity to change QHPs. Further, the updated tax return information may not yet be available via the data services hub. We believe that a rolling open enrollment period, with individual-specific dates would add complexity for families and increase risk selection. It would also eliminate the ability to conduct a single enrollment campaign when consumers could take action. We therefore maintain the proposed open enrollment period in §155.410(e) of this final

rule. With respect to the comment on aligning the enrollment period inside and outside the Exchange, we clarify that this rule only sets standards for Exchanges.

Comment: In response to our request for comment on the issue of auto-enrollment, several State agencies supported the rule's lack of auto-enrollment standards, because they perceived it as permitting flexibility. A few commenters explicitly opposed auto-enrollment. The remainder of the commenters supported the option for Exchanges to auto-enroll individuals who become unintentionally uninsured, but they expressed concerns over limiting an individual's right to choose his or her own QHP. Most commenters recommended that an Exchange send multiple notices to individuals facing potential auto-enrollment, and provide a 30 to 90-day period for individuals to change QHPs after being auto-enrolled.

Response: We have established flexibility for the Exchange to auto-enroll qualified individuals when the Exchange demonstrates to HHS that it has good cause to do so under §155.410(g) of this final rule. We expect to issue guidance outlining generally the circumstances under which HHS will approve Exchange auto-enrollment. HHS will also monitor auto-enrollment practices across Exchanges for appropriateness and effectiveness.

Comment: A few commenters stressed that any QHP into which qualified individuals are auto-enrolled must meet women's reproductive needs, as well as the need for local providers. The commenters recommended that the QHP in which an individual is auto-enrolled resemble any previous QHP coverage the qualified individual had.

Response: All QHPs must offer the essential health benefits established under section 1302(b) of the Affordable Care Act, which includes coverage of maternity and newborn care. Also, all QHPs must comply with Exchange network adequacy standards that ensure a sufficient number and type of providers to assure that all services will be accessible without unreasonable

delay, per §156.230. HHS will consider other commenter suggestions in developing guidance for §155.410(g) of this final rule.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.410 of the proposed rule, with the following modifications: in §155.410(b), we extended the end date of the initial enrollment period from February 28, 2014 to March 31, 2014. In §155.410(c)(2), we modified the initial enrollment period effective date such that a QHP selection must be received by the Exchange by the 15th of the month to secure an effective date of the first day of the following month. We also provided Exchanges flexibility to effectuate coverage more quickly if all QHP issuers offering coverage through the Exchange agree with the earlier dates, but noted that advance payments of the premium tax credit and cost-sharing reductions cannot begin until the first of the month. We further specified in §155.410(d) that the Exchange must send the notice of annual open enrollment no earlier than September 1st, and no later than September 30th of each year. Finally, in §155.410(g) we added an option for Exchanges to 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.

d. Special enrollment periods (§155.420)

In §155.420, we proposed that the Exchange must allow a qualified individual or enrollee to enroll in a QHP or change from one QHP to another outside of the annual open enrollment period if such individual qualifies for a special enrollment period. We proposed special enrollment period effective dates that generally followed the proposed initial enrollment period effective dates in §155.410.

For each special enrollment period we proposed a standard length of 60 days from the

date of the triggering event, unless the regulation specified otherwise. We requested comment on whether special enrollment periods, particularly those described in paragraphs §155.420(d)(4), §155.420(d)(6), and §155.420(d)(7), should have an alternate trigger or start date. The special enrollment periods we proposed were triggered by the following events:

- A qualified individual and any dependents losing other minimum essential coverage. We provided several examples of loss of coverage, and we sought comment on our proposal to limit this special enrollment period to the loss of minimum essential coverage, rather than loss of any coverage.
- A qualified individual gaining or becoming a dependent through marriage, birth, adoption, or placement for adoption. We solicited comment on whether States might consider expanding the special enrollment period to include gaining dependents through other life events.
- An individual, not previously lawfully present, gaining status as a citizen, national, or lawfully present individual in the U.S.
- Consistent with the Medicare Prescription Drug Program, a qualified individual experiencing an error in enrollment.
- An individual enrolled in a QHP adequately demonstrating to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract.
- An individual becoming newly eligible or newly ineligible for advance payments of the premium tax credit or experiencing a change in eligibility for cost-sharing reductions.
- New QHPs offered through the Exchange becoming available to a qualified individual or enrollee as a result of a permanent move.
- The individual is an Indian, as defined by the Indian Health Care Improvement Act. We

solicited comment on the potential implications on the process for verifying Indian status for purposes of this special enrollment period.

- A qualified individual or enrollee meeting other exceptional circumstances, as determined by the Exchange or HHS. Similar to section 9801 of the Code, we proposed that loss of coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage. We also proposed that loss of coverage not include situations allowing for a rescission as specified in 45 CFR 147.128.

We proposed that the Exchange allow an existing enrollee who qualifies for a special enrollment period to only change plans within the same metal level of coverage, as defined by section 1302(d) of the Affordable Care Act. We proposed a single exception for new eligibility for advance payments of the premium tax credit or change in eligibility for cost-sharing reductions. We requested comment as to whether we should provide an exception for catastrophic plan enrollees who become pregnant.

Comment: Several commenters sought clarification on the types of documents needed to qualify for a special enrollment period, as described in proposed §155.420(a). Some requested that the same verifications used for determining eligibility for coverage also be used to verify eligibility for a special enrollment period. Others, namely State agencies, requested State flexibility for determining special enrollment period eligibility.

Response: Exchanges must verify information outlined in §155.315 of the rule in order to make an eligibility determination, which includes a determination of eligibility for enrollment periods, per §155.305(b). Exchanges will be able to determine eligibility for most special enrollment periods using the information available through verifications outlined in §155.315.

However, given that the eligibility criteria for some of the special enrollment periods in §155.420 do not directly align with the criteria to establish eligibility for coverage through the Exchange or insurance affordability programs in §155.315, we expect Exchanges will use other verification standards and processes to determine eligibility for those particular special enrollment periods.

Comment: Several commenters recommended adding standards for Exchanges, QHP issuers and employers to notify an individual about his or her potential eligibility for a special enrollment period under proposed §155.420(a). For example, commenters recommended that employers include a notice about employees' potential eligibility for a special enrollment period with any health benefit change materials, or that QHP issuers notify enrollees who report a change in address.

Response: HHS will issue guidance pertaining to notices that may include information on special enrollment periods. We expect that Exchanges will include information about all enrollment periods both on their Web site and other informational resources.

Comment: Many commenters expressed general concerns about adverse selection. The commenters requested that individuals be limited to only one special enrollment period per month, and recommended limiting individuals' movement between QHPs during some or all special enrollment periods.

Response: While we recognize the need to limit the risk of adverse selection, we do not believe it is necessary to limit special enrollment periods, given the nature of the types of special enrollment periods. We received similar comments on the issue of limiting enrollees' movement between QHPs during open and special enrollment periods, and have responded to them in preamble for §155.410(e) and §155.420(f), respectively.

Comment: A few commenters suggested that the special enrollment periods described in

this section be aligned more closely with HIPAA rules for consistency inside and outside the Exchange. A few other commenters instead recommended aligning the special enrollment periods more closely with Medicare's special enrollment periods.

Response: Section 1311(c)(6) of the Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code (the HIPAA special enrollment periods) and reflect those available under part D of title XVIII of the Act. The final rule balances these two parameters by adopting relevant provisions from each. In response to comments requesting closer alignment with HIPAA rules, we have added regulatory text to §155.420(b)(2) to ensure first-of-the-month effective dates for qualified individuals who gain or become dependents through marriage, and for qualified individuals who lose minimum essential coverage. We have also aligned more closely with HIPAA rules by clarifying what is included under loss of minimum essential coverage in §155.420(e).

Comment: Many commenters made suggestions for effective dates under §155.420(b) similar to those made for the proposed §155.410(c) and §155.410(f) on effective dates during the initial and annual open enrollment periods.

Response: With the exception of the cases noted above in §155.420(b)(2), we have modified the special enrollment period effective dates in proposed §155.420(b) to align with initial enrollment period effective dates in §155.410(c) of this final rule. Our reasoning follows the same logic for both sections of the rule.

Comment: Several commenters recommended 30-day special enrollment periods, under proposed §155.420(c), consistent with the HIPAA standard, while several others supported the proposed 60-day periods, consistent with several special enrollment periods under the Medicare Prescription Drug Benefit Program. Several commenters recommended extending the periods for

as long as 120 days, particularly for vulnerable populations.

Response: Regarding the length of Exchange special enrollment periods outlined in §155.420(c) of the final rule, our experience with the Medicare Prescription Drug Benefit Program informs our decision to adopt the 60-day window, which generally conforms with several special enrollment periods in the Medicare Prescription Drug Benefit Manual that extend for two months beyond the month of a triggering event. We believe that this approach will give consumers the time they need to explore their coverage options through the Exchange, following a change in life circumstances. We have not extended the length of the enrollment period due to concerns about adverse selection. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: Several commenters, namely health insurance issuers, asked HHS not to add any additional special enrollment periods to those listed in proposed §155.420(d). Several other commenters recommended additions to the rule, including special enrollment periods for certain changes in plan provider networks, exhaustion of the COBRA disability extension, denial of services due to a provider's moral or religious opposition, and pregnancy.

Response: The Affordable Care Act establishes that Exchange special enrollment periods follow those specified in section 9801 of the Code and part D of title XVIII of the Act. The additional special enrollment periods suggested by commenters are not specified in the Code, nor are they similar enough to those available under the Act for HHS to include them in the final rule. Therefore the final rule implements the statute without additions. We note, however, that

the special enrollment period for exceptional circumstances in §155.420(d)(9) of this final rule provides an additional opportunity for enrollment when unforeseen circumstances arise.

Comment: Regarding proposed §155.420(d)(1), for individuals losing minimum essential coverage, many commenters sought clarification about what coverage it included. Several commenters questioned whether an individual would be eligible for this special enrollment period if offered COBRA, and how the policy related to proposed §155.420(e) and the Treasury proposed rule. Many commenters also sought assurance that loss of coverage included loss of coverage through Medicaid, CHIP and the BHP. One health insurance issuer recommended that loss of Medicaid or CHIP only be included if it is the result of a reported change in household income to an Exchange that disqualifies the individual or family from Medicaid or CHIP. A few health insurance issuers supported the language in proposed §155.420(d)(1) specifying loss of "minimum essential coverage," as opposed to any coverage, because it limits adverse selection by prohibiting individuals from dropping their substandard coverage when they became sick or injured. A few other commenters recommended Exchange flexibility to offer special enrollment periods to individuals losing non-minimum essential coverage.

Response: The Exchange establishment proposed rule preamble provides several examples of loss of coverage, including loss of Medicaid and CHIP, in accordance with section 9801(f)(3) of the Code. The examples remain accurate for this final rule. We have further clarified §155.420(e) in this final rule by specifying that loss of coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). This clarification aligns the special enrollment more closely with section 9801 of the Code. An individual could lose eligibility for Medicaid or CHIP as a result of a reported change in household income, or as a

result of other circumstances.

Qualified individuals are eligible for the loss of minimum essential coverage special enrollment period described in §155.420(d)(1), even if offered COBRA. The Treasury proposed rule defines COBRA coverage as minimum essential coverage only if the individual enrolls in such coverage. Therefore, if an individual elects and enrolls in COBRA, he or she cannot qualify for this special enrollment period until exhausting COBRA, as described in §155.420(e), but if the individual does not elect COBRA, he or she may take advantage of the Exchange special enrollment period. Regarding the recommendation to allow Exchanges to offer this special enrollment period to individuals losing non-minimum essential coverage, we have not adopted this policy in deference to the status the statute gives to minimum essential coverage.

Comment: Regarding the special enrollment period for individuals gaining or becoming a dependent as described in proposed §155.420(d)(2), many commenters made arguments for either limiting or for expanding the list of life events through which an individual becomes or gains a dependent. Several commenters recommended adding domestic partners, partners joined in civil unions, or dependents gained through guardianship. Several other commenters recommended that State law determine the types of dependents allowed.

Response: For the same reasons as described above, we do not find legal grounds for expanding the definition of dependents for the purpose of the special enrollment period described in §155.420(d)(2). Therefore, we retain this provision in this final rule without modification.

Comment: Regarding the special enrollment period for individuals becoming lawfully present, outlined in proposed §155.420(d)(3), several commenters questioned whether an individual moving from one lawfully present category to another would be granted this special enrollment period if it affected his or her eligibility for certain types of coverage.

Response: To qualify for coverage without advance payments of the premium tax credit or cost-sharing reductions through an Exchange under the special enrollment period described in both the proposed and final rule at §155.420(d)(3), the individual cannot have been previously lawfully present.

Comment: Regarding the special enrollment periods for errors in enrollment, and for contract violations, outlined in proposed §155.420(d)(4) and §155.420(d)(5) respectively, several commenters sought clarification on the kinds of events that would trigger them, and how individuals would demonstrate such events. A few health insurance issuers recommended appeals processes, either in conjunction with, or instead of these special enrollment periods. They recommended various limitations on the special enrollment period for errors in enrollment, and one commenter recommended that it be removed from the rule all together. Several other commenters sought clarification as to which entities are considered "agents of the Exchange or HHS," and recommended that at least QHPs be included as such agents.

Response: The special enrollment periods in §155.420(d)(4) and §155.420(d)(5) of this final rule are generally consistent with those offered under the Medicare Prescription Drug Program, as noted above. We expect Exchanges to develop guidance and standard operating procedures for considering requests for this special enrollment period. We encourage Exchanges to do so in consultation with health insurance issuers and other stakeholders. HHS may also provide future guidance to help Exchanges in operationalizing this special enrollment period.

Comment: Regarding the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed §155.420(d)(6), a couple of commenters sought clarification as to whether an individual newly released from incarceration would qualify for the special enrollment period, even if he or she did not qualify

for advance payments of the premium tax credit or did not experience a change in cost-sharing reductions.

Response: Qualified individuals newly released from incarceration are eligible for the special enrollment period afforded to individuals who gain access to a new QHP as a result of a permanent move, as outlined in §155.420(d)(7) of this final rule and as described further below.

Comment: A couple of commenters recommended that the special enrollment period for individuals newly eligible or ineligible for advance payments of the premium tax credit, outlined in proposed §155.420(d)(6), clarify that individuals may not qualify for this special enrollment period if they become eligible for an increase or decrease in their existing advance payments of the premium tax credit. Conversely, one commenter responding to HHS' request for comment recommended that this kind of special enrollment period be offered to all individuals who experience a change in income resulting in recalculation of their advance payments of the premium tax credit.

Response: The final rule specifies that individuals may only qualify for this special enrollment period in §155.420(d)(6) if they are newly eligible or ineligible for advance payments of the premium tax credit, and we do not believe clarification is necessary, as requested by the commenter. That said, if an individual experiences a change in his or her existing payments of the premium tax credit in tandem with a change in level of cost-sharing reductions, the individual could qualify for this special enrollment period.

Comment: One commenter recommended dividing the special enrollment period in proposed §155.420(d)(6) into two distinct periods – one for individuals gaining eligibility for advance payments of the premium tax credit or experiencing a change in cost-sharing reductions, and a second for individuals whose employer-sponsored coverage ceases to meet affordability or

minimum value standards.

Response: While we have not added a special enrollment period specifically for individuals whose employer-sponsored coverage ceases to meet affordability or minimum value standards, as recommended by the commenter, we clarify in §155.420(e) that loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). We believe that between the special enrollment periods offered for loss of minimum essential coverage in §155.420(d)(1) and for employer-sponsored coverage becoming unaffordable in §155.420(d)(6), individuals will have ample opportunities to enroll in coverage through the Exchange.

Comment: Regarding the special enrollment period for permanent moves, outlined in proposed §155.420(d)(7), one health insurance issuer recommended that the provision be revised so that it would only be a triggering event if an enrollee moves permanently outside the service area of his or her existing QHP. Several health insurance issuers also recommended that individuals who move across State lines receive an eligibility determination from the Exchange in their new State.

Response: The special enrollment period in §155.420(d)(7) is similar to the special enrollment period under part D of title XVIII of the Act, as directed by section 1311(c)(6) of the Affordable Care Act. Both are intended to afford individuals the full range of plan options when they relocate. Individuals moving to a new State should receive an eligibility determination from their new State's Exchange. Qualified individuals are responsible for reporting a permanent move.

Comment: Several commenters recommended that a special enrollment period be triggered by the date of a permanent move described in §155.420(d)(7), while others

recommended it be triggered by the date the individual reports the move to the Exchange, with a time-limited time window in which to report it. In cases where an individual's eligibility for employer-sponsored coverage terminates or changes, in response to proposed §155.420(d)(1) and (d)(6) respectively, several commenters recommended that the period be triggered by the date the employee learns of the termination or change. Other commenters recommended that it be triggered by the actual date of the termination of or change in coverage. In cases where an individual becomes newly eligible for advance payments of the premium tax credit or experiences a change in cost-sharing reductions, in response to proposed §155.420(d)(6), several commenters recommended that the period be triggered by the date the individual experienced a change in circumstances, while others recommended it be triggered by the date of the Exchange's official eligibility determination. Several other commenters recommended less structured approaches, such as leaving the trigger up to the consumer with the change in circumstances, or allowing the particular circumstances to dictate the trigger. Many commenters also recommended that individuals be permitted to seek special enrollment periods in advance of a known triggering event.

Response: We expect to issue guidance to help Exchanges determine how to define the triggering events and consider the recommendations received. We believe it is critical to establish a balance between minimizing gaps in coverage and the need to avoid coverage overlaps when premium tax credits are involved. Exchanges may grant special enrollment periods in advance of a triggering event, so long as the effective date of coverage does not occur before the triggering event, and so long as there is no overlap in coverage for which the individual receives advance payments of the premium tax credit or cost-sharing reductions while enrolled in other minimum essential coverage.

Comment: Regarding the special enrollment period for Indians, outlined in proposed §155.420(d)(8), some commenters expressed support, while others either opposed it or recommended that States have flexibility to adopt their own special Indian provisions. Many commenters sought further clarification on how the Exchange would verify an individual's status as an Indian. Some disagreed with the definition of Indian outlined by HHS in proposed §155.420(d)(8), and some provided a detailed legal analysis to support their position. Others recommended allowing special enrollment periods more frequently than once per month in cases where any QHP network excludes Indian Health Service, tribal, or urban Indian providers or when a QHP drops such providers from its network.

Response: Consistent with the proposed rule, HHS is codifying the special monthly enrollment period for Indians in accordance with section 1311(c)(6)(D) of the Affordable Care Act. Sections 155.300 and 155.350(c) of this final rule address comments submitted regarding the definition of Indian and verification of an individual's status as an Indian as it relates to eligibility for cost-sharing reductions. The same verification rules apply to eligibility for this special enrollment period. As stated above, we do not believe that there is legal flexibility to include additional special enrollment periods.

Comment: Regarding the special enrollment period for individuals with exceptional circumstances, outlined in proposed §155.420(d)(9), many commenters supported the broad language, while several others recommended more specificity. A few commenters recommended that States, not HHS, determine the exceptional circumstances.

Response: We have modified the language in §155.420(d)(9) to permit individuals to request a special enrollment period by demonstrating to their Exchange that they meet exceptional circumstances. The modified language establishes that individuals must demonstrate

such circumstances in accordance with guidelines issued by HHS. Consistent with examples outlined in the proposed rule preamble, HHS's guidance for this special enrollment period will outline circumstances when HHS may grant special enrollment periods directly, such as in cases of natural disasters.

Comment: A few commenters supported the exclusion from special enrollment periods when individuals failed to pay their premiums on a timely basis, outlined in proposed §155.420(e), while several other commenters explicitly opposed this provision. Several commenters only opposed the exclusion for individuals who failed to pay their COBRA premium on a timely basis, noting that many people are likely to elect COBRA without realizing that there are more affordable coverage options through the Exchange.

Response: The limitation described in §155.420(e) reflects similar limitations in both section 9801 of the Code, and part D of title XVIII, as directed by section 1311(c)(6) of the Affordable Care Act. As stated in the response to comments on §155.420(d)(1) (for individuals losing minimum essential coverage) individuals are free to decline COBRA and instead enroll in a QHP through the Exchange. We have also added clarification to §155.420(e) to indicate which circumstances are included under loss of minimum essential coverage.

Comment: While a few health insurance issuers supported the limits on special enrollment periods outlined in proposed §155.420(f), most commenters either opposed the provision outright, or recommended additional exceptions, such as exceptions for pregnant women, or for the special enrollment periods described in proposed §155.420(d)(2), §155.420(d)(4), §155.420(d)(5), and §155.420(d)(8). One commenter noted that because the special enrollment periods were generally not tied to changes in an individual's health status, they did not pose a risk of adverse selection.

Response: We have removed §155.420(f) from the final rule because special enrollment periods are generally not tied to changes in an individual's health status, and are unlikely to increase the potential for adverse selection. Just as qualified individuals are free to move between metal levels during the initial and annual open enrollment periods, they are also free to do so during special enrollment periods.

Summary of Regulatory Changes

We are finalizing the standards proposed in §155.420 of the proposed rule, with several modifications: in §155.420(b) related to effective dates, we modified the special enrollment period effective dates such that a QHP selection must be received by the Exchange by the 15th of the month to secure an effective date of the first day of the following month. We provided Exchanges flexibility to effectuate coverage more quickly by demonstrating to HHS that all QHP issuers offering coverage through the Exchange agree with the earlier dates, but noted that advance payments of the premium tax credit and cost-sharing reductions cannot begin until the first of the month. This limitation on advance payments of the premium tax credit and cost-sharing reductions also applies to individuals enrolling mid-month as a result of birth, adoption or placement for adoption. As an exception to the effective dates above, we specified in §155.420(b)(2)(ii) that in the case of marriage or in the case where a qualified individual loses minimum essential coverage, the Exchange must always ensure coverage is effective on the first day of the following month, consistent with HIPAA rules. We clarify that to qualify for the special enrollment period under §155.420(d)(9) individuals must demonstrate their exceptional circumstances to the Exchange, in accordance with guidelines issued by HHS. In §155.420(e) we clarify that loss of coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Finally, we remove the restrictions in §155.420(f) that had previously

prohibited individuals from moving between metal levels during special enrollment periods.

e. Termination of coverage (§155.430)

We proposed that the Exchange must permit an enrollee to terminate his or her coverage in a QHP with appropriate notice to the Exchange or the QHP. We proposed that the Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage under a specific list of circumstances: the enrollee is no longer eligible for coverage; the enrollee obtains other minimum essential coverage; payment of premiums cease; the enrollee's coverage is rescinded in accordance with §147.128 of this title; the enrollee's QHP is terminated or decertified; or the enrollee changes from one plan to another during the annual open enrollment or a special enrollment period in accordance with sections §155.410 and §155.420.

We also proposed that the Exchange establish maintenance of records procedures for termination of coverage, track the number of individuals for whom coverage has been terminated and submit that information to HHS promptly and without undue delay, establish terms for reasonable accommodations for individuals with mental or cognitive conditions, and retain records in order to facilitate audit functions.

Additionally, we proposed that in the case of a termination requested by an enrollee, the last day of coverage for an enrollee is the termination date specified by the enrollee, provided that the Exchange and QHP receive reasonable notice. We proposed that if the Exchange or the QHP do not receive reasonable notice, the last day of coverage is the first day after a reasonable amount of time has passed. We proposed that in the case of a termination by the Exchange or a QHP as a result of an enrollee obtaining new minimum essential coverage, the last day of coverage is the day before the effective date of the new coverage. We solicited comments

regarding how Exchanges can work with QHP issuers to implement this proposal. We also proposed standards for termination effective dates in the case of a termination by the Exchange or a QHP as a result of an enrollee changing QHPs. Finally, we proposed that for individuals not covered by the previous termination effective dates, the last day of coverage would be either the fourteenth or the last day of the month, depending on when termination of coverage was initiated.

Comment: A handful of commenters asked us to clarify what length of time would qualify as "reasonable notice," as referenced in the proposed rule in §155.430(b)(1). Some commenters suggested 24 hours while others suggested 30 days. The most common suggestion was 14 days. Other commenters requested that the final rule specify the methods consumers may use to notify their intent to terminate coverage.

Response: In this final rule, we clarify in §155.430(d)(1) that "reasonable notice" is defined as 14 days from the requested date of termination. We want to ensure that individuals who have access to other coverage sources do not need to maintain Exchange coverage longer than necessary. In §155.430(d)(2)(ii) of the final rule, we further state that the date of termination of coverage is 14 days from the request if the enrollee does not give reasonable notice to terminate coverage. We also note in §155.430(d)(2)(iii) that coverage may be terminated in fewer than 14 days, per the request of the individual, if his or her QHP issuer is able to effectuate terminations more quickly. We do not specify how an individual will notify the Exchange that they wish to terminate coverage; rather, we leave this up to States to define how such transmissions may be received. This is in part because a request for termination may be received through either the Exchange or the QHP, and also because we wish to allow maximum flexibility to Exchanges.

Comment: Several commenters requested clarification regarding how the grace period for non-payment of premiums would work for individuals receiving advance payments of the premium tax credit and whether these policies differ for those who are not.

Response: We clarify in §155.430(b)(2)(ii)(A) and (B) of this final rule that the grace periods for non-payment of premiums are not the same for individuals receiving advance payments of the premium tax credit and other enrollees.. The 90-day grace period for non-payment of premiums for individuals receiving advance payments of the premium tax credit is addressed in §156.270(d). In §155.430(d)(5) of the final rule, we clarify that the last day of coverage for individuals not receiving advance payments of the premium tax credit should be consistent with existing State laws regarding grace periods for non-payment.

Comment: One commenter suggested that Exchanges be allowed to designate either the Exchange or the QHP to receive termination notifications in order to reduce duplication. A few commenters did not support the proposed standard in §155.430(c) that QHP issuers report termination of coverage data to HHS because of privacy concerns.

Response: We did not accept the commenter's recommendation. Regardless of which entity the enrollee contacts to terminate coverage, the Exchange and QHP issuers will need to notify the other entity of the enrollee's coverage status to keep updated enrollment records. In addition, HHS needs to know when coverage is terminated to stop advance payments of the premium tax credit. As such, we maintain the reporting standards in §155.430(c) in this final rule.

Comment: A few commenters asked that language in proposed §155.430(c)(3), which directs QHP issuers to make reasonable accommodations when terminating coverage for individuals with mental or cognitive conditions, be broadened to include all individuals with

disabilities, not just individuals with mental or cognitive disabilities.

Response: We broaden the final rule in §155.430(c)(3) to state that reasonable accommodations must be undertaken when terminating coverage for individuals with disabilities as defined by the Americans with Disabilities Act.

Comment: A handful of commenters thought that provisions of section 2703 of the PHS Act were in conflict with the termination provisions contained in the Exchange establishment proposed rule in §155.430(d)(2) because the proposed rule outlined dates of termination when an enrollee gains other minimum essential coverage. Commenters interpreted this to mean that an individual must terminate his or her Exchange coverage and said that issuers cannot terminate an individual's coverage because they gain access to other minimum essential coverage.

Response: We removed language indicating that a QHP must terminate an enrollee's coverage should they gain access to other minimum essential coverage in the final rule. Therefore, we do not believe there is a conflict with section 2703 of the PHS Act. We note, however, that the enrollee would no longer be eligible for advance payments of the premium tax credit or cost-sharing reductions if they have access to other minimum essential coverage.

Comment: Several commenters requested that CMS put in place "safeguards" so as to minimize or eliminate coverage gaps for individuals who become newly eligible for Medicaid, CHIP, or the BHP. Other commenters requested that individuals not have their Exchange coverage terminated when they become eligible but do not enroll in Medicare.
Many other commenters recommended that the final rule state that individuals cannot be automatically terminated from Exchange coverage should they be found eligible for Medicaid, CHIP, or the BHP.

Response: In order to address these concerns, we have added §155.430(d)(2)(iv) to the

final rule to specify that if an individual enrolls in Medicaid, CHIP, or the BHP and wishes to terminate his or her Exchange coverage, then the last day of Exchange coverage is the day before such other coverage begins. We note that neither the proposed nor the final rule state that individuals will automatically be terminated from Exchange coverage should they be found eligible for Medicare. We also note that we remove proposed §155.430(d)(4) from this final rule because the provisions are no longer necessary given the termination dates outlined in §155.430(d)(1-6) of the final rule.

Comment: Some commenters requested that the Exchange establish a broad definition of "minimum essential coverage," as well as flexibility in terms of when coverage is terminated because an enrollee gains access to other minimum essential coverage.

Response: We do not define minimum essential coverage in this final rule as this definition is included in section 5000A(f) of the Code. Individuals do not have to terminate coverage and QHP issuers must not terminate coverage when an individual becomes enrolled in other minimum essential coverage unless such individual requests a termination. In §155.430(d)(2) of this final rule, we clarify that the last day of coverage when an enrollee gains access to other minimum essential coverage is the date requested by the enrollee, should they give reasonable notice unless the QHP issuer can effectuate the termination earlier, or, the day before new coverage begins if the enrollee becomes eligible for Medicaid, CHIP, or the Basic Health Program. Individuals and QHP issuers do not have to terminate coverage when an individual becomes enrolled in other minimum essential coverage. However, if an individual is eligible for or enrolled in other minimum essential coverage, such individual may no longer be included in the coverage family, as indicated in §155.305(f)(1)(B) and can no longer receive advance payments of the premium tax credit or cost-sharing reductions.

Comment: A few commenters asked that HHS track reasons for termination of coverage.

Response: Additional details regarding data that must be submitted to HHS will be addressed in future guidance.

Comment: Several commenters noted that the proposed termination effective date in §155.430(d)(3) was inaccurate as it was prospective, when rescission is by definition retrospective.

Response: We removed §155.430(d)(3) in the final rule to eliminate a date of termination for a rescission in accordance with §147.128. The termination of coverage date will vary based on the situation.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.430 of the proposed rule, with the following modifications: we clarified paragraph (b)(1) to specify that an enrollee must be permitted to terminate his or her coverage, including as a result of obtaining other minimum essential coverage. In new paragraph (b)(2)(A), we clarified that enrollees receiving advance payments of the premium tax credit will be terminated from coverage when the grace period described in §156.270 is exhausted. In §155.430(c)(2) we clarified that the Exchange must transmit data on terminations to QHP issuers and HHS promptly and without undue delay. We also broadened the regulation text in §155.430(c)(3) regarding individuals with disabilities to state that QHP issuers must create standards to accommodate all individuals with disabilities when terminating such individuals' coverage, and defined individuals with disabilities as those groups identified under the Americans with Disabilities Act. In addition, in paragraph §155.430(d)(1) we defined "reasonable notice" given by the enrollee to the Exchange or QHP issuer to terminate coverage as 14 days.

In paragraph §155.430(d)(2), we described the last day of coverage as the date specified by the enrollee; fourteen days after the termination date requested by the enrollee, if the enrollee does not provide reasonable notice; or fewer than 14 days if the individual's QHP issuer is able to terminate coverage more quickly. Paragraph (d)(3) was added to clarify that for an enrollee who is no longer eligible for coverage through the Exchange, the last day of coverage is the last day of the month following the month in which notice described by §155.330(e) is sent by the QHP. We noted in new paragraph (d)(4) that for an enrollee receiving advance payments of the premium tax credit, the last day of coverage will be the last day of the first month of the grace period. In paragraph (d)(5) we noted that the last day of coverage for non-payment of premiums for enrollees not receiving advance payment of the premium tax credit is in accordance with State law.

6. Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)

The Affordable Care Act directs each State that chooses to operate an Exchange to establish insurance options for small businesses through a Small Business Health Options Program (SHOP). States that choose to operate an Exchange may also merge SHOP with the individual market Exchange.

a. Standards for the establishment of a SHOP (§155.700)

In §155.700, we proposed the general standard that an Exchange must provide for the establishment of a SHOP that meets the standards of this subpart.

Comment: Some commenters requested that, in the case of a State that establishes either a SHOP or an Exchange serving the individual market, but not both, the Secretary certify this as an Exchange in accordance with the Affordable Care Act.

Response: Section 1311(b) of the Affordable Care Act envisions an Exchange that both

facilitates the purchase of QHPs and provides for the establishment of a SHOP. We interpret this to mean that a State that fails to fulfill both standards has not established an Exchange in accordance with the Affordable Care Act.

Comment: Some commenters proposed that the SHOP may want to fulfill additional functions outside the scope of the proposed rule in order to offer employers a streamlined experience when managing their employee benefits. These commenters proposed that the SHOP sell other types of insurance, administer COBRA on behalf of participating employers, administer flexible spending accounts, assist small employers in setting up Section 125 plans, and oversee wellness programs.

Response: Section 155.1000(b) directs the Exchanges to only offer health plans that have been certified as QHPs. We will take these comments into account as we consider future guidance on the offering of other products on the Exchange.

Comment: One commenter requested that we clarify the meaning of "coordination" and sharing of information between the Exchange and the SHOP as described in the preamble to the proposed rule.

Response: As discussed in the proposed rule, there are many economies of scale that may arise from integrated Exchange and SHOP establishment. We believe that there are natural opportunities for the Exchange and the SHOP to benefit from shared data sources and coordinated activities.

Comment: One commenter discussed the possible use of health reimbursement arrangements from multiple employers as a means of purchasing coverage through the SHOP, aggregating premium contributions from multiple employers to support the employee's purchase of a QHP.

Response: The possible use of different forms of health reimbursement arrangement to purchase coverage through the Exchange or the SHOP is beyond the scope of this final rule, and will be addressed in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.700 of the proposed rule, with one modification: in new paragraph (b), we added a definition of "group participation rule."

b. Functions of a SHOP (§155.705)

In §155.705, we proposed the minimum functions of a SHOP. The SHOP must carry out all the functions of an Exchange described in this subpart and in subparts C, E, and K of this part, except for standards related to individual eligibility determinations, enrollment standards related to qualified individuals, standards related to the premium tax credit calculator, standards related to exemptions from the individual coverage requirement, and standards related to the payment of premiums by individuals, Indian tribes, tribal organizations, and urban tribal organizations.

We also proposed that a SHOP must adhere to additional enrollment and eligibility standards described in §155.710, §155.715, §155.720, §155.725, and §155.730. In addition, the SHOP must at a minimum facilitate the special enrollment periods described in §156.285(b)(2). Specifically, we proposed that all of the special enrollment periods that apply to individual market coverage in the Exchange also apply in the SHOP, with the exception of special enrollment periods associated with a change in citizenship status or lawful presence or eligibility for advance payments of the premium tax credit or cost-sharing reductions. We noted that the proposed rule did not eliminate any special enrollment periods established by other laws (including, but not limited to, HIPAA (Pub. L. 104-191)). We also clarified that the two

exceptions described above also apply to qualified employees in a SHOP. We invited comment on special enrollment periods for the SHOP and how they might differ from those that would apply to the Exchange for the individual market.

We proposed that a qualified employer may choose a level of coverage under section 1302(b) of the Affordable Care Act, within which a qualified employee may choose an available plan at that level of coverage. We also provided flexibility for a SHOP to choose additional ways for qualified employers to offer one or more plans to their employees and listed several potential options. We sought comment on our proposed approach, which established a standard for employee choice within a level of cost sharing while providing SHOPs the option to offer broader employee choices among plans of different levels of cost sharing.

We also invited comment on whether QHPs offered in the SHOP should waive application of minimum participation rules at the level of the QHP or issuer; whether a minimum participation rule applied at the SHOP level is desirable; and if so, how the rate should be calculated, what the rate should be, and whether the minimum participation rate should be established in Federal regulation.

To simplify the administration of health benefits among small employers, we proposed that the SHOP allow qualified employers to receive a single monthly bill for all QHPs in which their employees are enrolled and to pay a single monthly amount to the SHOP. We further proposed that the SHOP collect from employers offering multiple coverage options a single cumulative premium payment.

We proposed three unique criteria for certification for a SHOP: rate setting and premium payment standards; enrollment period standards; and enrollment process standards. Specifically, we proposed that the SHOP direct all QHP issuers to make any changes to rates at a uniform

interval that is either monthly, quarterly, or annually. As described in §155.725, we proposed to permit rolling enrollment in a SHOP, which allows qualified employers to purchase coverage in QHPs at any point during the year. We invited comment on whether we should allow a more permissive or restrictive timeframe than monthly, quarterly, or annually. We also invited comment on what rates should be used to determine premiums during the plan year.

We also proposed that if a State merges the individual and small group risk pools, the Exchange may only offer QHPs to employers and employees that meet the deductibles set forth in section 1302(c)(2)(A) of the Affordable Care Act. If a State does not merge the individual and small group risk pools, we proposed that a SHOP may only make small group QHPs available to qualified employees.

Finally, we proposed to codify the statutory option for States to allow insurers in the large group market to sell large group products to large groups through the SHOP beginning in 2017.

Comment: We received several comments regarding the proposed exclusion of a premium calculator from the minimum functions for the SHOP in proposed §155.705(a)(3). Some commenters requested that a premium calculator be included, arguing that it assists employers in estimating their total costs. Other commenters noted that instead of providing individuals with an estimation of their cost of coverage after any applicable tax credits or cost sharing reductions, a premium calculator in the SHOP may show employees their premiums after any applicable employer contributions.

Response: We believe that a premium calculator will assist employees in determining their cost of coverage after any applicable employer contribution at little to no additional burden on SHOPs or employers. Therefore, we have added new §155.705(b)(11) in this final rule to clarify that a SHOP must provide a premium calculator to qualified employers. To support States

in developing a premium calculator for the SHOP, HHS will provide model computer code.

Comment: In response to the proposed §155.705(b)(1), which stated that a SHOP must facilitate the special enrollment periods described in §156.285(b)(2), many commenters expressed concern about the preamble discussion regarding a lack of a special enrollment period in SHOP based on change in immigration or citizenship status. These commenters recommended that, rather than clarifying that a SHOP would not need to offer a special enrollment period based on a change in immigration or citizenship status, HHS should clarify that special enrollment periods in SHOP should be based on whether an individual is newly hired by a "qualified" employer or whether an individual becomes a newly eligible "qualified employee." Further, commenters recommended that HHS clarify that new hires or newly eligible qualified employees should not need a special enrollment period because the qualified employers should allow them to enroll at any time during the plan year.

Response: We have modified the language in §155.725(g) and §156.285(b) in this final rule to clarify the provision of an enrollment period for an employee who becomes a "qualified employee" rather than just new hires. We believe this clarification more accurately reflects the intent that enrollment periods will be provided to those who become qualified employees outside of the initial or annual open enrollment period, such as employees who have, for example, completed an employer's waiting period for benefits, changed from part time to full time status, or are newly hired.

Comment: We received numerous comments in response to proposed §155.705(b)(2) and (3) on the employee and employer choice provisions. Many commenters supported additional employee choice options, such as offering plans across cost-sharing levels. Other commenters supported more limited employee choice options, often expressing concern that allowing

employee choice across cost-sharing levels and even within a cost-sharing level would result in substantial risk selection. Some commenters supported broad employer choice to offer either a wider or narrower range of employee choices, including offering a single QHP. Several commenters suggested that the Affordable Care Act directs the SHOP to give employers the option to offer a single QHP. One commenter suggested initially implementing a pure employer choice model with no employee choice. A few commenters suggested adding a defined contribution model to the list of additional choice options from the preamble to the proposed rule.

Response: We believe the proposed rule appropriately balances the employee choice standards of the Affordable Care Act with flexibility for SHOPs to allow employers greater choice in their plan offering options. Under this model, employees will likely have more plan choice than they currently have in the small group market, where traditionally an employer offers only one plan to its employees.[9] However, nothing in the Affordable Care Act limits a SHOP's ability to offer an employer additional options, including choice across cost-sharing levels. We believe that States and SHOPs are best positioned to strike the proper balance among competing priorities: flexibility, meaningful consumer choice, and protection of the market against risk selection. Thus, we have retained the proposed wording of §155.705(b)(2) and (b)(3) in the final rule.

We also note specifically that the SHOP may allow employers to offer only one plan to its employees. We believe this is supported by section 1312 of the Affordable Care Act, which defines a "qualified employer" as a small employer that elects to make all full-time employees eligible for one or more QHPs offered in the small group market through the Exchange.

[9] Exhibit 4.2: Among Firms Offering Health Benefits, Percentage of Covered Workers in Firms Offering One, Two, or Three or More Plan Types, by Firm Size, 2011, Employer Health Benefits 2011 Annual Survey. Kaiser Family Foundation.

However, we do not believe that this definition establishes that the SHOP must give employers the option to offer only a single plan.

With regard to the comments on defined contribution, we note that the method through which an employer offers QHPs to its employees is independent of how the employer chooses to contribute toward the premium cost of coverage.

Comment: One commenter expressed concern that allowing employers to enroll their qualified employees into a single QHP may trigger the application of ERISA, and that the Affordable Care Act was intended to supersede ERISA and provide stronger Federal and State protections to consumers.

Response: Issues on the application of ERISA are within the purview of Department of Labor. In this rule, we clarify that a SHOP may permit employers to offer employees a single QHP.

Comment: One commenter on proposed §155.705 requested that HHS clarify whether the employer or the SHOP will be responsible for maintaining records on employee QHP selections, and further expressed concern that the employer would be unable to monitor its employees' QHP selections.

Response: As described in §155.705(b)(4)(i) of this final rule, the SHOP is responsible for providing each qualified employer with a bill listing the employees enrolled under that employer, the QHP each employee is enrolled in, and the cost of the QHP.

Comment: We received several comments regarding the proposed §155.705(b)(4), which stated that a SHOP must provide a "single bill" to qualified employers and aggregate premium payments from employers. Many commenters supported this proposal, noting that it was essential to the effective operation of providing employees with a choice of QHP and should ease

the burden on small employers of administering group health benefits. Some commenters recommended that the single bill list for each employee the portion of the premium the employee is responsible for and the portion of the premium for which the employer is responsible, while others suggested that the SHOP assist employers in calculating an average premium for its employees. In contrast, other commenters suggested that premium aggregation should not be a minimum function of the SHOP or should be optional for employers not providing their employees with a choice of QHP. Some commenters noted that health plans currently provide their own the billing services and that a standard on the SHOP to aggregate premiums may add to the administrative cost of selling QHPs through the SHOP.

Response: We believe that premium aggregation dramatically decreases the burden on an employer of participating in the SHOP by permitting the employer to write a single check for the total premium amount due. We do not believe that SHOP premium aggregation will increase the administrative burden on issuers who already perform billing services, because such issuers will no longer have to submit, track, and support a large number of paper bills to individual employers. Further, we believe that the process of resolving discrepancies will be simplified, since the issuer only needs to reconcile with one entity – the SHOP.

Additionally, we believe that bills provided by the SHOP should contain in addition to the total amount due by the employer, the portion of each employee's premium for which the employer is responsible and the portion for which the employee is responsible, and have revised paragraph §155.705(b)(4)(i) of this final rule to reflect this clarification. We note that this information may be collected on the SHOP single employer application. The SHOP may also include an average premium on the billing statement to assist employers in smoothing premium costs between employees.

Comment: Some commenters responding to proposed §155.705 requested clarification regarding procedures for dispute resolution for potential scenarios where the SHOP failed to remit payment to QHP issuers in a timely manner or failed to collect the correct amount from employers. One commenter recommended that proposed §155.720(d) allow a grace period for employees and employers for making premium payments based on evidence of a "good faith" effort.

Response: Because States vary dramatically in statutory and regulatory standards related to non-payment or late payment of premiums, we do not believe a Federal uniform standard and process could effectively prevent such errors. Instead, we encourage SHOPs to create standard operating procedures regarding the payment and remittance of premiums. We also recommend that SHOPs standardize grace periods across QHPs. Because proper oversight of the flow of funds is essential, we direct the SHOP to maintain records and evidence of standard accounting procedures in order to allow for effective auditing of the premium aggregation service.

Comment: Commenters generally supported the option for a State to merge the individual and small group markets subject to the provisions of proposed §155.705(b)(7).While commenters had a variety of views on the advisability of merging the markets, most commenters agreed that, if a State merges the markets, QHPs offered to small employers in the merged market must meet the maximum deductible provision in section 1302(c) of the Affordable Care Act. One commenter said that QHPs in a merged market should not be subject to a maximum deductible, and another commenter stated that there should be no restrictions on the deductible in the small group market.

Response: We do not believe that the statute allows issuers who participate in a merged market to be exempted from offering small businesses the maximum deductible in the

Affordable Care Act; therefore, we are finalizing §155.705(b)(7) as proposed.

Comment: Commenters expressed concern that limiting employees to small group market QHPs rather than in any QHP that meets the maximum deductible provision in section 1302(c) of the Affordable Care Act may make it more difficult to achieve portability of coverage across employment situations, including periods of unemployment and self-employment, and may complicate the aggregation of employer contributions from different employers. The commenters asked that the standard be changed or removed in the final rule.

Response: While we understand the concern about portability between small group and individual market products, section 1311(b)(1)(B) of the Affordable Care Act clearly states that the SHOP is "designed to assist qualified employers in the State who are small employers in facilitating the enrollment of their employees in QHPs offered in the small group market in the State." We have therefore retained the language in §155.705(b)(8) in this final rule.

Comment: Several commenters expressed concerns about the possibility of adverse selection and other market disruptions that might result from a State's choice to allow large group market issuers to offer QHPs in the large group market through the SHOP. Two commenters specifically expressed concern about an automatic SHOP expansion to the large group market. Several commenters recommended that States not expand the SHOP; one commenter suggested that HHS delay the expansion; and one commenter asked that HHS create safeguards to prevent adverse selection. Finally, one commenter asked that we interpret section 1312(f)(2)(b) of the Affordable Care Act to allow States the latitude to expand the SHOP earlier than 2017.

Response: Section 2701(a)(5) of the PHS Act provides that if the State exercises the option of offering large group market QHPs in the SHOP, the rating rules in section 2701 that

apply to the small group market will also apply to all coverage offered in that State's large group market, except for self-insured group health plans. A State must specifically elect the expansion. We also do not believe that we have the authority to delay – or to allow earlier implementation of – the State's ability to make this election. Accordingly, we are not modifying the final rule to provide for any such modifications.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.705 of the proposed rule, with the following modifications: in paragraph (b)(4)(i), we clarified the data elements that must be included in the monthly bill sent by the SHOP. In new paragraph (b)(4)(iii), we added a standard for the SHOP to 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, to conform to the standards for the individual Exchange. We also clarified in paragraph (b)(5) that the SHOP must ensure that each QHP meets the certification standards in §156.285. In new paragraphs (b)(10) and (11), we noted that the SHOP may authorize minimum participation standards on certain conditions, and established that the SHOP must develop a premium calculator to assist qualified employers and employees. Finally, we made several technical clarifications and modifications.

c. Eligibility standards for SHOP (§155.710)

In §155.710, we proposed the eligibility standards for qualified employers and qualified employees seeking to purchase coverage through a SHOP, and proposed to codify the general standard that the SHOP make QHPs available to qualified employers. Specifically, we proposed that the SHOP ensure that an entity is a small employer, or an employer with no fewer than one employee and no more than 100 employees, unless a State elects to limit enrollment in the small

group market to employers with no more than 50 employees until January 1, 2016.

We also proposed to define "employer," "small employer," and "large employer" based on the PHS Act, and to adopt the PHS Act methodology for counting employees, where employees are counted equally regardless of their status as a part time employee or full time employee. Noting that States use a variety of methods to determine employer size for purposes of determining eligibility for the small group market, we solicited comment on this approach.

We further proposed that the SHOP must ensure a qualified employer provides an offer of coverage through a SHOP to all of its full-time employees, and that the employer can elect to cover all employees through the SHOP serving the employer's principal business address or by providing coverage to each eligible employee through the SHOP serving the employee's primary worksite. In cases where the employer elects to cover all employees through the SHOPs serving their worksites, we proposed that a SHOP must accept the application of such an employer, subject to any minimum participation rules authorized by the SHOP. In addition, we proposed to allow an employer participating in the SHOP to continue its participation if the number of workers employed fluctuates after the employer's initial eligibility determination. We also clarified that only an employee who receives an offer of coverage through the SHOP from a qualified employer may be a qualified employee.

Comment: Many commenters addressed the question of whether businesses consisting entirely of sole proprietors, 2 percent S-corporation shareholders, and their family members, with no common law employees, should be eligible to purchase coverage through a SHOP. Several commenters were in favor of either including sole proprietors in the definition of eligible employer or allowing States to decide whether to expand their definition of a small group to encompass sole proprietors, stating that this would be analogous to the HIPAA interpretation that

States could extend HIPAA protections to more employers. Other commenters suggested deferring to State definitions of small group to avoid confusion and minimize possible differences between the SHOP and the outside market.

Many commenters supported allowing sole proprietors to choose either Exchange individual market or SHOP coverage. Some commenters suggested deferring to State law to allow those States to continue offering small group coverage to sole proprietors. Many other commenters supported the proposed rule's exclusion of sole proprietors from the small group market, noting that the current rationale for allowing sole proprietors to purchase in the small group market — to provide access to a guaranteed issue product with modified community rating — will not be relevant in 2014 because of individual market reforms. Several of these commenters suggested that the final rule make clear that sole proprietors are eligible for coverage in the Exchange. Two commenters suggested using the COBRA standard to determine the number of employees, which would also exclude sole proprietors. Other commenters who supported the rule as proposed suggested that allowing sole proprietors and S-corporation owners a choice between markets would create possible adverse risk selection.

Response: The Affordable Care Act and the proposed rule base their definitions of "employer," "employee," "small employer," and "large employer" on the definitions in the Public Health Service Act (PHS Act). Section 2791 of the PHS Act incorporates by reference the definition of employee in section 3(6) of ERISA. Further, section 2791 provides that an employer is defined by reference to section 3(5) of ERISA. To be an employer eligible to purchase coverage through the SHOP, the employer must employ at least one common law employee. Under 29 CFR 2510.3-3, an employee would not include a sole proprietor or the sole proprietor's spouse.

We find no authority to interpret what constitutes a group health plan differently than set forth in the proposed rule. And, we note that even though both markets will have guaranteed issue and similar rating rules, enrollment of individuals is limited to the annual open enrollment period while enrollment of groups can occur throughout the year. We have therefore retained the definitions in proposed §155.20, and our interpretation of what constitutes a group health plan.

Comment: A number of commenters addressed the issue of how employees should be counted in determining employer size. Commenters noted that States use different methods to calculate employer group size when determining small group market eligibility. Several commenters noted that there are also different Federal methods for determining employer size for different purposes, and that these differing methods may be confusing to small employers. While some commenters supported the proposed approach, to count all full time and part time employees, other commenters suggested specific alternatives, including but not limited to a full-time equivalent method like that used in section 4980H of the Code, as added by section 1513 of the Affordable Care Act, to determine whether an employer is a large employer; the full-time equivalent method used to determine whether Federal COBRA continuation of coverage standards apply; or counting full-time employees only. Finally, a number of commenters suggested that each Exchange defer to the applicable State's method of determining group size or transitioning from current State methods of counting employees to a Federal method.

Response: CMS has previously issued guidance on determining employer size that includes part-time employees in the count.[10] For example, the method described in the preamble to the proposed rule would count part-time employees as full employees. A second method proposed in a 2004 proposed rule issued by the Department of the Treasury, the Department of

[10] HCFA Insurance Standards Bulletin Series No. 99-03 (September 1999), posted online at https://www.cms.gov/HealthInsReformforConsume/downloads/HIPAA-99-03.pdf .

Labor, and HHS, in which the number of full-time equivalent employees is determined.[11] Because of the range of comments received to the proposed rule and because the method of counting employees has implications that extend beyond the operation of the SHOP, we are not finalizing at this time a rule for determining employer size. We are considering future rulemaking to address the method of determining employer size for purposes of deciding whether an employer is a small employer or a large employer.

Comment: Several commenters suggested that the proposed rule articulate the method of determining whether a small employer is subject to or exempt from the shared responsibility standards, since that determination is different from the determination of eligibility for participation in the SHOP.

Response: Formal guidance about the method of determining whether a small employer is subject to the shared responsibility provisions is outside the scope of this final rule.

Comment: Several commenters supported the flexibility of the employer and employee eligibility standards in proposed §155.710, including allowing employers with worksites in the service areas of multiple SHOPs to offer coverage to their employees through the SHOP serving the employees' worksites. Some commenters requested clarification regarding the coordination of information necessary for the effective implementation of such an eligibility standard. Other commenters requested clarification of how employer groups can calculate premiums in a way that mitigates the effects of age rating in instances where workers obtain coverage through more than one Exchange. Finally, one commenter recommended that employee eligibility be limited to the State in which the employer's headquarters is located.

Response: We recognize the benefits of allowing employers in multiple States flexibility

[11] Notice of Proposed Rulemaking for Health Coverage Portability: Tolling Certain Time Periods and Interaction with the Family and Medical Leave Act Under HIPAA Titles I and IV, 69 CFR 78000-78825,

regarding the SHOPs in which they may opt to enroll. We believe this eligibility standard does not establish a significant level of coordination between SHOPs, though nothing in this section would preclude a SHOP from establishing processes or standard operating procedures to coordinate across service areas. Employers electing to participate in multiple SHOPs must meet the eligibility standards of each SHOP in which they wish to participate and prior to 2017 may not employ more than 100 employees in total in accordance with section 1312(f)(2) of the Affordable Care Act. We acknowledge, however, that standards related to the calculation of premiums in the small group market may vary from State to State in a manner that does not allow differences in cost due to age or location to be spread easily among all employees across State lines.

Comment: One commenter objected to the proposed §155.710(b)(2), which stated that the SHOP must ensure that a qualified employer provides an offer of coverage through the SHOP to all full-time employees because it places an administrative burden on the SHOP and would be difficult to enforce. Other commenters suggested that a multi-employer plan should be able to offer coverage to its participants through the SHOP only to the employees of a participating small employer covered under a collective bargaining agreement.

Response: Our eligibility process allows the SHOP to accept an attestation by an employer that it will offer coverage to all of its full-time employees, minimizing the commenter's concern about burden. Multiemployer plans that qualify as QHPs may offer coverage in SHOP but, like other QHPs, must follow rules applicable to QHPs. Additionally, we intend to address commenters' concerns surrounding multi-employer plans in future guidance.

Comment: One commenter suggested that additional guidance might be needed with regard to multi-employer plans purchasing coverage through the SHOP, particularly with regard

to determining the work site, establishing eligibility and enrollment procedures, billing and premium collection, and other administrative procedures.

Response: Multiemployer plans can play a role as an aggregator of premium contributions, and an arranger of coverage, and intend to address commenters' concerns in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.710 of the proposed rule without substantive modification.

d. Eligibility determination process for SHOP (§155.715)

In §155.715, we proposed that a SHOP determine eligibility consistent with the standards described in §155.710. Specifically, we proposed that a SHOP must verify either through the attestation of the employer or through additional methods developed by the SHOP, that a qualified employer has fulfilled all of the standards specified in §155.710, including that the employer is a small employer, it is offering coverage through the SHOP to all full-time employees, as well as verifying that at least one employee works in the SHOP's service area.

Consistent with the statutory directive for HHS to provide a single, streamlined application form, we also proposed that the SHOP use only two application forms: one for qualified employers and one for qualified employees. We further proposed that for the purpose of determining eligibility in the SHOP, the SHOP may use the information attested to by the employer or employee on the application but must, at a minimum, verify that an individual attempting to enter the SHOP as an employee is listed on the qualified employer's roster of employees to whom coverage is offered. We also proposed that the SHOP have processes to resolve occasions when the SHOP has a reason to doubt the information provided through the employer and employee applications. In addition, similar to the individual market Exchange

standards, we proposed that the SHOP notify an employer or employee seeking coverage of the SHOP's eligibility determination and the employer or employee's right to appeal.

Finally, we proposed that if a qualified employer ceases to purchase any coverage through the SHOP, the SHOP must ensure that: (1) each QHP terminates the coverage of the employer's qualified employees enrolled in QHPs through the SHOP; and (2) each of the employer's qualified employees enrolled in a QHP through the SHOP is notified of the employer's withdrawal and its termination of coverage prior to such withdrawal and termination. We solicited comments on whether this notification must inform the employee about his or her eligibility for a special enrollment period in the Exchange and about the process of being determined eligible for insurance affordability programs.

Comment: We received several comments regarding the eligibility determination process for employees proposed in §155.715. Some commenters opposed the processes for individual employee verification, stating that the process may increase the administrative burden on businesses. Others suggested that the SHOP should not verify employee eligibility and questioned the Secretary's authority for such verifications. Commenters recommended that any SHOP eligibility process conform to the standards of sections 1411(g) and 1411(h) of the Affordable Care Act. Some additionally proposed an alternative process whereby employers applying for coverage in a SHOP present a list of qualified employees with reference to associated Employment Identification Numbers (EIN) in order to prevent employer and employees applicants from gaming the eligibility process. Commenters additionally recommended that the final rule prohibit the SHOP from collecting information for verification of citizenship status or eligibility for the advance payment of the premium tax credit, as described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act.

Response: We note that in accordance with §155.705(a), SHOPs must comply with the standards of part 155 subpart C including the privacy and security standards of §155.260 and §155.270. These sections implement section 1411(g) of the Affordable Care Act.

The employee eligibility process as proposed would direct the SHOP to verify only that an employee applying for coverage through the SHOP is a qualified employee – an employee offered coverage by a qualified employer. We believe that such verification is necessary to ensure the effective operation of the SHOP and the prevention of abuse. An employee applying to the SHOP for coverage may easily be both verified and determined to be a qualified employee by the SHOP solely on the list of qualified employees provided to the SHOP by the employer.

Because citizenship verification is the responsibility of the employer at the time of hiring, we have added language in this final rule to clarify that the SHOP will not perform re-verification of citizenship status.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.715 of the proposed rule, with the following modifications: in new paragraph (c)(3), we clarified that a SHOP may only collect the minimum information necessary to verify the information provided in an application. In new paragraph (c)(4) we reiterated that the SHOP may not perform individual eligibility determinations as described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act. In paragraph (d)(1)(iv)(A), we established that the SHOP must mention an employer's right to appeal in any notice of denial of eligibility. In paragraph (g)(2), we specified that the SHOP must ensure that any employees affected by a qualified employer's withdrawal from the SHOP are notified and receive information about other coverage options. Finally, we made several changes throughout this section to improve the precision of the language used.

e. Enrollment of employees into QHPs under SHOP (§155.720)

In §155.720, we proposed that the SHOP establish a uniform enrollment timeline and process, standardized to a plan year, for all employers and QHPs in the SHOP. In addition, we proposed that the SHOP must ensure that qualified employees who select a QHP are notified of the effective date of coverage, whether such notice is executed by the QHP or by the SHOP.

We also proposed that information maintained by the SHOP must include records of qualified employer participation and qualified employee enrollment, and that reconciliation of enrollment information with QHPs occur at least monthly. We invited comments on whether we should establish target dates or guidelines so that multi-State qualified employers are subject to consistent rules.

Finally, we proposed that if a qualified employee voluntarily terminates coverage from a QHP, the SHOP must notify the individual's employer.

Comment: Several commenters suggested that proposed §155.720(a) clarify the duties of the SHOP and QHP issuers when facilitating employee enrollment into QHPs.

Response: Section 155.705 directs a SHOP to carry out the minimum functions in other subparts of the part. Consistent with the proposed rule, §155.720(c)(2) of the final rule directs a SHOP to fulfill the standards of §155.400, which establishes standards related to enrollment of individuals into QHPs.

Comment: One commenter requested clarification that QHP issuers do not have to participate in both the SHOP and individual Exchanges.

Response: Nothing in this part establishes that an issuer must participate in both the SHOP and the individual Exchange. However, we note that Exchanges may wish to establish such participation in both markets as a condition of certification.

Comment: One commenter to this section recommended automatic enrollment of employees into new QHPs when there are mergers between QHP issuers or when one QHP offered by a specific QHP issuer is no longer offered, but there are other options available to the individual through the same QHP issuer.

Response: We believe that States may wish to take variable approaches to managing the enrollment; and therefore, we are not establishing a standard to offer automatic enrollment in this final rule.

Comment: Several commenters to proposed §155.720(b) recommended that the final rule afford States further flexibility with respect to enrollment timelines. A few commenters suggested that the SHOP base its timelines on eligibility rules for enrollment on the current market practices. A few commenters recommended that the final rule exclude any target dates and guidelines in §155.720, while another commenter recommended that the rule establish basic guidelines and leave the selection of exact dates to the SHOP. Yet another commenter expressed concern that the proposed rule did not provide sufficient flexibility for industries that typically begin coverage on October 1 and recommended that SHOPs be permitted to provide special group enrollment for those groups or amend the rule to afford States greater flexibility to address those circumstances. Conversely, another commenter proposed that §155.720 include target dates and guidelines so that multi-State employers are subject to consistent rules. One commenter supported similar enrollment processes and timelines across QHPs to allow qualified employees the greatest opportunity to select preferred plans and ease administrative burden for multi-State employers.

Response: We believe that §155.720 provides adequate flexibility for a State to develop its process in a way that is most suitable to local situations. Thus, we have not included specific

dates in the section and have allowed States flexibility to address specific needs or concerns, including current market environment and special industries.

Comment: Two commenters responding to this section and §155.725 recommended that HHS develop a transaction standard with respect to collected enrollment information.

Response: We plan to provide guidance on the timing, format, and content of the enrollment information transmissions to QHP issuers.

Comment: Several commenters suggested proposed §155.720(e) specify how SHOPs can ensure that QHPs provide notices to employees of effective coverage dates. One commenter supported the policy that SHOPs be held accountable for employees receiving notices of effective dates of coverage. One commenter recommended that QHPs transmit confirmation of enrollment to the SHOP, and another urged HHS not to add a standard that the SHOP must send a duplicate notification to the enrollee.

Response: SHOPs must be able to enforce the notification standard; we believe that §155.720 provides a State with the flexibility to establish its SHOP enrollment timeline, procedures, and enforcement mechanisms that work best for the particular State. The QHP should be responsible for sending notification; we have clarified in §155.720(e) of this final rule that a QHP, and not the SHOP, must send the notification.

Comment: In response to proposed §155.720(f) and (g), one commenter opposed the policy for the SHOP to reconcile information and keep records, noting that it is unclear under the Affordable Care Act why SHOP should maintain records.

Response: The reconciliation of information and the retention of records of participants and participant information by the SHOP is a necessary standard for the smooth operation of the SHOP and effective oversight of the SHOP.

Comment: Several commenters to proposed §155.720(g) supported the idea of reconciliation of enrollment information but disagreed on the frequency and on who should determine the frequency. One recommended that this paragraph establish monthly reconciliation and that SHOPs allow QHPs to query a SHOP at any time for information on qualified employers and employees. A few commenters recommended flexibility for States to establish reporting and auditing standards.

Response: We recognize the need for periodic reconciliation of enrollment information between the SHOP and the QHPs. However, States should have the flexibility to determine how often such reconciliation is necessary, provided that reconciliation is completed no less frequently than once per month. Therefore, we are not adding a more specific standard in the final rule.

Comment: In response to the standards in proposed §155.720(h) related to termination of a qualified employee, some commenters recommended allowing SHOPs to ensure that disenrollment requests from current employees to come through the employer because such a process would ensure the employer receives notification and is able to communicate to the employee the potential consequences of disenrollment. One commenter recommended that an employee who ends employment should consult with the employer regarding available coverage options after employment ends. Another commenter recommended the notification standard be placed on the QHP issuer and not on the SHOP.

Response: We believe that §155.720(h) of this final rule ensures that an employer will receive appropriate notification while preserving an employee's ability to terminate coverage without the added step of consulting with the employer or creating an additional administrative

burden on the employer. We believe that the notification standard should remain with the SHOP and that the associated administrative burden will be minimal.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.720 of the proposed rule, with the following modification: in paragraph (f), we clarified that SHOPs must retain records for ten years, which is changed from the proposed seven years. We added new paragraph (i), which directs the SHOP to report to the IRS employer participation and employee enrollment information for tax administration purposes. Finally, we made a few technical modifications to streamline the regulation text.

f. Enrollment periods under SHOP (§155.725)

In §155.725, we proposed that the SHOP adhere to the start of the initial open enrollment period for the Exchange, which is October 1, 2013 for coverage effective January 1, 2014, and ensure that QHP issuers adhere to coverage effective dates in accordance with §156.260. We noted that the initial open enrollment date represents the first date employers may begin participating in the SHOP. In addition, to align enrollment processes between the SHOP and the small group market, we proposed a rolling enrollment process in the SHOP whereby qualified employers may begin participating in the SHOP at any time during the year.

We invited comment on two provisions related to SHOP enrollment: that qualified employers may enroll or change plans once per year or during an applicable special enrollment period; and that an employer's plan may not align with the calendar year.

We also proposed an annual employer election period in advance of the annual open enrollment period, during which time a qualified employer could modify the employer contribution towards the premium cost of coverage and the plans it intended to offer to

employees during the next plan year. We noted that this annual election period may be specific to each qualified employer and therefore must occur at a fixed point in the plan year, not at a fixed point during the calendar year. In addition, we proposed that the SHOP must notify participating employers that their annual election period is approaching, and solicited comment on this standard and whether we should establish that the notice be sent at a specified interval (for example, 30 days before the relevant election period).

We solicited comment on our proposal that the SHOP establish an annual employee open enrollment period for qualified employees, to occur at a fixed point during the plan year, during which the employee would have the option to renew or change coverage. We proposed that a qualified employee who is hired outside of the initial or annual open enrollment period would have a specified window set by the SHOP to seek coverage in a QHP beginning on the first day of employment. We also proposed that the SHOP establish effective dates of coverage for qualified employees consistent with §155.720. Finally, we proposed that if an enrollee remains eligible for coverage in a QHP through the SHOP, the individual will remain in the QHP selected during the previous plan year with limited exceptions, in which case the individual would be disenrolled at the end of the coverage year. We invited comments on our approach to differentiating individual and small group market enrollment and the proposed structure for initial, rolling, and annual open enrollment through the SHOP.

Comment: In response to proposed §155.725(a), some commenters opposed aligning the enrollment periods in §155.725 with the individual Exchange and recommended that SHOP enrollment should be aligned with other group markets.

Response: In §155.725(a), we align the SHOP initial open enrollment period with an individual Exchange for the first opportunity when coverage may be purchased through the

SHOP. Under §155.725(b), we establish rolling enrollment in the SHOP, which we believe is consistent with current practice in the small group market where plan years do not necessarily correspond to calendar years. We have retained these provisions in the final rule.

Comment: In response to the standards in proposed §155.725(a)(2), one commenter requested clarification that effective dates depend on the completion of eligibility and enrollment standards, and recommend that such standards must be met by December 7, 2013 to secure a coverage effective date of January 1, 2014.

Response: A SHOP must permit an individual to enroll in a QHP only after a qualified employee has been determined eligible and has completed any enrollment standards. We believe that the standards in §155.410 of this final rule provide sufficient time for QHP issuers to effectuate enrollment.

Comment: A few commenters on this section recommended adding a standard that SHOPs develop a plan to encourage maximum enrollment during the initial open enrollment period, noting concerns about adverse selection if certain employers wait to enroll until health care needs make it more advantageous. One commenter recommended allowing employers to pro-rate their initial year of participation and then begin their next plan year on January 1st of the following year to minimize public confusion and aid implementation.

Response: We believe that States have the flexibility under the rule to best assess their local market environment and to develop plans to encourage enrollment and discourage adverse selection.

Comment: Many commenters on proposed §155.725(e) recommended that the annual employee open enrollment period last at least 30 days. Some commenters recommended that open enrollment should be standardized for all QHPs. Several supported a notification period for

employees before the annual enrollment period. One commenter recommended the employer, and not the SHOP, decide the open enrollment period, and a few commenters recommended the Federal government defer to States to establish open enrollment periods.

Response: We have added language to §155.725(e) of this final rule establishing a standardized open enrollment period of at least 30 days. We note that States will have the flexibility to establish open enrollment periods based on the specific market landscape of the State, and believe that §155.725 provides that flexibility. We further believe that employees should receive a notification in advance of the open enrollment period and have added a standard in new §155.725(f) that the SHOP provide notification to qualified employees of the open enrollment period in advance of the period.

Comment: Several commenters on proposed §155.725(d) supported the policy that the SHOP must notify the employer in advance of the annual employer election period. A few supported a notification period of 30 days or at least 30 days, one requested flexibility in determining when employers must be notified, and one recommended that the notification period align with the outside market to prevent additional administrative burden on QHPs. Conversely, one commenter opposed a notification standard for the SHOP, stating that this function is currently handled by health insurance issuers.

Response: We believe that the SHOP should provide notification of the open enrollment period but do not believe that we should prescribe specific timing for the notification. We believe that §155.725 of the proposed rule provides the SHOP with the requested flexibility for notification timing. Finally, we note that the SHOP is the appropriate entity to notify employers because a single employer could have employees enrolled in QHPs across several issuers. Therefore, we are not changing this standard in the final rule.

Comment: A few commenters on proposed §155.725(c) recommended that the annual employer election period last at least 30 days. One commenter recommended that an employer must submit an application to participate in SHOP at least 120 days prior to the start of the plan year.

Response: We recognize the importance of an annual employer election period of at least 30 days and have added language to §155.725(c) to that effect. However, we note that States have the flexibility to establish longer annual employer election periods if they so choose.

Comment: In response to proposed §155.725(h), one commenter requested clarification on the auto-enrollment process where a QHP ceases to exist and an individual does not select another QHP.

Response: Auto-enrollment in the SHOP is only applicable per redesignated §155.725(i) of this final rule in situations in which a qualified employee enrolled in a QHP through the SHOP remains eligible for coverage. In such cases, the employee will remain in the QHP selected during the previous year unless the qualified employee terminates coverage, enrolls in another QHP, or the QHP is no longer available. We note that if a QHP ceases to exist, resulting in a loss of minimum essential coverage for the enrollee, the enrollee will be eligible for a special enrollment period per §155.725(a)(3). We also note that under §156.290(b), a QHP issuer that does not seek recertification with the Exchange for a QHP must provide written notice to each enrollee. However, in these cases where an enrollee's former QHP is no longer available, there is no auto-enrollment standard in the SHOP should the individual not select another QHP during a special enrollment period or open enrollment period.

Comment: Many commenters offered feedback on the proposed §155.725(g), which stated that the SHOP must establish effective dates of coverage for enrollees in the SHOP. A few

commenters requested that the final rule clarify the SHOP's obligation to establish coverage effective dates. One commenter recommended that coverage take effect on the first day of the month following the date of enrollment for enrollment transactions completed by the 20th of the month. In cases where enrollment is completed after the 20th, the commenter recommended that coverage take effect on the first day of the month that follows the next month. In contrast, some commenters disagreed with the policy that SHOPs must establish effective dates of coverage, noting that employers and carriers currently perform this function.

Response: Per redesignated §155.725(h) of this final rule, the SHOP must establish coverage effective dates consistent with §155.720. We believe that a single policy of effective dates in the SHOP ensures consistency and note that we proposed using the same effective dates as the individual Exchange for the initial enrollment period in order to increase the administrative simplicity for Exchanges and issuers. We believe the §155.410 standards provide sufficient time for processing enrollment information before the effective date of coverage. Therefore, we are finalizing redesignated §155.725(h), as proposed. We further note that a SHOP must not only establish effective dates but must also ensure notification of the effective dates in accordance with §155.720.

Comment: Some commenters to §155.725 recommended that employees receive advance notice if the QHP in which they are enrolled will no longer be offered through the SHOP for the upcoming plan year. Another commenter recommended that employees in this circumstance receive advanced notice of other affordable options, including insurance affordability programs.

Response: We note that §156.285(d)(1)(ii) of this final rule directs any QHP issuer that chooses not to renew its participation in the SHOP to notify affected enrollees and qualified employers. We believe that this notification standard, combined with the annual open enrollment

period, provides sufficient opportunity for enrollees to review their coverage options and make a new plan selection. Therefore, we are not adding a notification standard in this section.

Comment: Several commenters on proposed §155.725(f) supported the policy that SHOPs provide coverage to any new employees hired outside of the initial or annual open enrollment period and that SHOPs be able to make that coverage available on the employee's first day of employment. One commenter recommended a predetermined, regulated length of time for the enrollment period. One commenter expressed concern with the limited ability to amend an employee's coverage and recommended that employees have an opportunity to state a case for needing to change coverage similar to special enrollment rules. One commenter suggested that there should be a special enrollment period if an employer reduces its contribution. Other commenters questioned how this standard relates to probationary periods, specifically the Affordable Care Act provision that permits group plans to impose waiting periods of no more than 90 days for coverage of new employees.

Response: In general, we recognize the importance of providing coverage to new employees hired outside of the initial or annual open enrollment. Thus, we have clarified in redesignated §155.725(g) of this final rule to assure that the SHOP provides an employee who becomes a qualified employee a period to seek coverage that would be effective on the first day of becoming a qualified employee rather than on the first day of employment. This revision refines the standard to encompass not only new employees, but also situations where an employee moves from part to full time status or completes a waiting period. In the case of a waiting period, an employee could become a qualified employee under §155.710(e) when the qualified employer makes an offer of coverage after the waiting period is over. It still retains the ability for a new and qualified employee to seek coverage on the first day of employment. States

will be able to set a time for this period under §155.720. We believe that §155.725 does not preclude a State from creating special enrollment periods in addition to the ones established by the rule.

Comment: One commenter on proposed §155.725(h) recommended that because eligibility of a qualified employee to enroll in a QHP through the SHOP is available on the basis of employment by a qualified employer, the employer should be responsible for renewing its employees' coverage at the end of a plan year.

Response: We believe that §155.725(c) adequately addresses that concern by specifically establishing that a SHOP must provide qualified employers with an annual election period in which a qualified employer may change its participation in the SHOP for the next year, including the method it makes QHPs available to qualified employees, the level of employer contribution, the level of coverage offered, and the QHP or plans offered. Therefore, we are finalizing this provision as proposed.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.725 of the proposed rule, with the following modifications: in new paragraph (a)(3) we clarified that a SHOP must provide the special enrollment periods described in §155.420, with the exception of those described in paragraphs (d)(3) and (6) of that section. We provided in paragraph (c) that the SHOP must allow qualified employers a period of no less than 30 days to alter plan selections prior to the open enrollment period. We established in paragraph (e) that the annual employee open enrollment period must be standardized, and must be at least 30 days. In new paragraph (f), we direct the SHOP to provide notification to a qualified employee of the annual open enrollment period. In redesignated paragraph (g) we clarified that the SHOP must offer an enrollment period

to newly qualified employees. Finally, we redesignated proposed paragraphs (f), (g), and (h) as paragraphs (g), (h), and (i), respectively, and made several minor changes throughout this section to make the regulation text more precise and to add clarity.

g. Application standards for SHOP (§155.730)

In 155.730, we outlined the proposed application-related standards for participation in the SHOP. Specifically, we proposed that the SHOP use a single employer application and the information the application should collect (that is, employer name and address, number of employees, employer identification number, list of qualified employees and SSNs). We sought comment on what, if any, other employer information SHOPs should collect via the employer application.

Similarly, we proposed that the SHOP must use a single employee application for each employee to collect eligibility information and QHP selection. We noted that a SHOP may modify or reduce the individual Exchange application for SHOP applicants, if desired and subject to approval by the Secretary. We also proposed that a SHOP may also use a model single employer application and model single employee application created by HHS or an alternative application approved by HHS. Finally, we proposed that the SHOP must allow employers and employees to submit their eligibility and enrollment information consistent with §155.405(c).

Comment: We received several comments regarding the preamble discussion in the proposed rule that the SHOP should not make eligibility determinations for Medicaid or CHIP. Many commenters recommended that the final rule outline a role for the SHOP in providing information about these programs.

Response: There are a number of ways that employees can learn about insurance affordability programs. We do not think that the application for SHOP is the most effective

venue for providing this information.

Comment: We received several comments related to the limitations on the information that may be collected on SHOP applications in accordance with proposed §155.730(a). Some commenters requested that the final rule not impose any limitations on the information that the SHOP may request of employees, noting that such restrictions could limit how well the SHOP can serve qualified employers and qualified employees. Other commenters supported the proposed rule's focus on a simple application standard and limiting the information collected to information necessary to facilitate applications, eligibility determinations, and enrollment.

Response: We believe that limiting the collection of information on the application to data relevant for eligibility determinations, enrollment, and reporting by the SHOP or by QHP issuers balances the need to minimize the burden placed on applicants with the information needs of the SHOP and QHP issuers. Therefore, we are finalizing the provisions of §155.730(a) as proposed.

Comment: One commenter suggested that the application collect the NAIC code of each employer applying to the SHOP under proposed §155.730(a).

Response: We do not believe that it is essential for the SHOP application to collect each employer's NAIC code, since it is beyond what is minimally necessary for the purpose of the SHOP.

Comment: Some commenters were strongly opposed to the standard that the SHOP collect the social security number (SSN) of employees on the employer application in accordance with proposed §155.730(a)(4). These commenters stated that effective alternate methods of authenticating employees exist, recommended that this standard be removed from the final rule.

Response: While employees may be effectively authenticated without the employer providing employee SSN on the employer application, employee taxpayer identification numbers (most commonly an employee's SSN) are needed for QHP issuers to comply with the standards of section 1502 of the Affordable Care Act. Although we retain the employees' names and taxpayer identification numbers as elements of the employer application, we have clarified in §155.715(c)(4), that the SHOP may not re-verify the citizenship status of the employee or make a determination of eligibility for an advance payments of the premium tax credit. We note that employees already provide their Social Security number to employers for a variety of purposes and this information is disclosed by the employer to both State and Federal agencies of for such purposes as unemployment insurance and tax purposes.

Comment: Some commenters requested that the SHOP be permitted to adopt an alternative employer or employee application without obtaining formal approval from HHS, as proposed in §155.730(e), in order to prevent the delay in the adoption of such applications. Other commenters agreed with the proposed policy that HHS approve any alternative application to ensure it meets the standards of this section.

Response: The HHS review of any proposed alternative application is intended to ensure that it conforms to the standards proposed in this section. Therefore, we are maintaining the standard under §155.730(e), as proposed.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §155.730 of the proposed rule, with two modifications. In paragraph (e) we clarified that a SHOP may develop and submit for HHS approval an alternative application for employers and employees. Additionally, in new paragraph (g) we provide for additional safeguards to address commenters concern regarding the collection

and use of dependent information for purposes other than processing enrollment in a QHP and made several minor changes throughout this section to make the regulation text more precise and to add clarity.

7. Subpart K - Exchange Functions: Certification of Qualified Health Plans

This subpart codifies section 1311(d)(4)(A) of the Affordable Care Act, which establishes that Exchanges, at a minimum, implement procedures for the certification, recertification, and decertification of health plans as QHPs, consistent with guidelines developed by HHS. This subpart also clarifies the Exchanges' responsibility related to the inclusion in the Exchange of certain multi-State plans. We note that as States establish Exchanges, each State has choices related to certification of QHPs for the Exchange through the piece of legislation, executive order, or charter that creates the Exchange. Alternatively, the Exchange itself may be able to exercise discretion under existing State and Federal law.

a. Certification standards for QHPs (§155.1000)

In §155.1000, we proposed the overall responsibilities of an Exchange to certify QHPs. We proposed that QHPs must have in effect a certification issued or recognized by the Exchange as QHPs and that an Exchange may only make available as a QHP a health plan that has in effect a certification issued or recognized by the Exchange as a QHP. We proposed to define a multi-State plan as a plan under contract with OPM to offer a multi-State plan that offers a benefits package that is uniform in each State and consists of the benefit design standards described in section 1302 of the Affordable Care Act; meets all standards for QHPs; and meets Federal rating standards in accordance with section 2701 of the PHS Act, or a State's more restrictive rating standards, if applicable.

We proposed that an Exchange may certify a QHP if the QHP meets minimum certification standards described in subpart C of part 156 and if the Exchange determines the QHP is in the interest of qualified individuals and qualified employers in the State. We noted than an Exchange could adopt an "any qualified plan" certification, engage in selective certification, or negotiate with plans on a case-by-case basis; the proposal also permitted an Exchange to establish additional certification criteria.

Comment: A few commenters requested that HHS redefine a multi-State plan in proposed §155.1000(a) as a plan that is described under section 1334 of the Affordable Care Act to ensure continuous alignment between this final rule and forthcoming regulations on multi-State plans promulgated by the U.S. Office of Personnel Management (OPM).

Response: We believe the commenters' approach would better align this final rule with forthcoming regulations on multi-State plans. Therefore, we are revising the regulation text in final §155.1000 to reference section 1334 of the Affordable Care Act. The final rule in this subpart has been revised throughout to acknowledge the role of OPM in certifying multi-State plans.

Comment: Several commenters requested additional information on how the Office of Personnel Management will administer multi-State plans. Commenters proposed specific recommendations, including that OPM deem existing health plans that operate in multiple States as multi-State plans, or that multi-State plans include protections for certain types of benefits (for example, benefits related to end-stage renal disease).

Response: The standards and processes related to multi-State plans will be addressed in forthcoming regulations implementing section 1334 of the Affordable Care Act promulgated by OPM. These issues are outside the scope of this final rule, which only addresses multi-State

plans in connection with Exchange obligations to recognize multi-State plans as certified by OPM.

Comment: Several commenters requested that HHS clarify the language in proposed §155.1000(c)(2) permitting an Exchange to certify a QHP if the Exchange determines that such QHP is in the interest of qualified individuals and qualified employers.

Response: We interpret §155.1000(c)(2), as proposed and as finalized, as providing an Exchange with broad discretion to certify health plans that otherwise meet the QHP certification standards specified in part 156 in a way that best meets the needs of local consumers and businesses. We refer commenters to pages 41891 and 41892 of the Exchange establishment proposed rule for a more comprehensive discussion of the strategies an Exchange could use to apply the "interest" test, including consideration of the reasonableness of the expected costs supporting the QHP's premium and cost-sharing structure, past performance of the QHP issuer, quality improvement activities, enhancements of provider networks, the QHP service area, or past rate increases.

Comment: A few commenters requested that HHS clarify the meaning of the exclusions in proposed §155.1000(c)(2)(i) through (iii), which place certain limits on an Exchange's ability to exercise the "interest" test described in proposed §155.1000(c)(2).

Response: As proposed and as finalized, §155.1000(c)(2)(i)-(iii) codifies sections 1311(e)(1)(B)(i)-(iii) of the Affordable Care Act, which limits an Exchange's ability to apply the "interest" test in certifying qualified QHPs. Specifically, we clarify that an Exchange cannot exclude an otherwise eligible QHP on the sole basis that it is a fee-for-service plan, through the use of premium price controls, or because the QHP covers treatments or services necessary to prevent patient deaths that the Exchange determines are inappropriate or too costly.

Comment: One commenter requested that the final rule clarify that any certification standards or processes developed in accordance with this section apply uniformly to any subsidiary Exchanges. Another commenter requested that a QHP issuer be permitted to operate statewide, even where subsidiary Exchanges cover smaller service areas.

Response: There may be multiple compelling and appropriate reasons for a State to create additional standards, or to take a different approach to certification, in different market regions. For example, a State may wish to employ different contracting strategies in a highly competitive, urban service area versus a rural service area. Further, we believe that the definition of an Exchange in §155.20 and the authority to have a regional or subsidiary Exchange provided in §155.140 establish that a subsidiary or regional Exchange not only must meet all Exchange responsibilities, but also have the same authority and discretion as an Exchange that serves an entire State. Therefore, we are not establishing uniform standards for subsidiary Exchanges within a State; we note, however, that HHS must review and approve subsidiary Exchanges. We expect that States will consider the implications of developing subsidiary Exchanges, including the potential effects on issuer participation in the State.

Comment: One commenter generally expressed concern about aligning market rules and consumer protections inside and outside of the Exchange.

Response: We note that nothing in the final rule limits a State's ability to adjust market and other rules outside of the Exchange to better align with the rules and protections that exist within the Exchange.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1000 of the proposed rule, with the following modification: we revised the definition of a multi-State plan in paragraph (a) to mean a

QHP that is offered in accordance with section 1334 of the Affordable Care Act, to ensure ongoing consistency with forthcoming regulations implementing this section. In paragraph (b), we amended the provision to clarify the language.

b. Certification process for QHPs (§155.1010)

In §155.1010, we proposed that the Exchange establish procedures for the certification of QHPs that are consistent with the certification criteria outlined in §155.1000(c). We also proposed that a multi-State plan offered through OPM be deemed certified by an Exchange and noted that multi-State plans will need to meet all the standards for a QHP, as determined by OPM. To ensure consumers have a robust selection of QHPs during the open enrollment period, we further proposed that the Exchange complete the certification of QHPs prior to the open enrollment periods established in §155.410. Finally, we proposed that the Exchange monitor QHP issuers for demonstration of ongoing compliance with certification standards.

Comment: In response to proposed §155.1010(a) on QHP certification, a number of commenters expressed support for Exchange flexibility in designing the certification process. Conversely, several commenters recommended a uniform, national set of certification standards and processes and proposed specific features, such as that the certification process consider past premium increases, an issuer's medical loss ratio, quality information, or provider payment standards. Several commenters requested that the final rule provide additional detail on the certification standards that Exchanges will use to evaluate QHPs.

Response: We recognize the importance of ensuring a basic set of uniform consumer protections across all Exchange markets through the setting of minimum certification standards for QHP issuers. We believe that States are best positioned to adapt and expand on these standards to meet the needs of consumers served by the Exchange, given local market conditions.

Therefore, while Exchanges have discretion to identify certification standards above and beyond those provided for in the final rule, including the features suggested by commenters, we are not specifying additional elements in this final rule.

Comment: Many commenters expressed support for a specific contracting model the Exchange could adopt in accordance with proposed §155.1010(a); of these, approximately half endorsed an "any willing plan" approach, in which the Exchange would contract with all QHPs that meet the relevant certification criteria. The other half of the commenters favored more proactive forms of "active purchasing," including selective contracting with QHPs.

Response: As we noted in the preamble to the Exchange establishment proposed rule, we believe that an Exchange's certification approach may vary based upon market conditions and the needs of consumers in the service area. Accordingly, in this final rule, we offer flexibility to Exchanges on several elements of the certification process, including the contracting model, so that Exchanges can appropriately adjust to local market conditions and consumer needs. An Exchange could adopt its contracting approach from a variety of contracting strategies, including an any-qualified plan approach, a selective contracting model based on predetermined criteria, or direct negotiation with all or a subset of QHPs. Therefore, we are not prescribing a specific contracting model in this final rule.

Comment: Many commenters expressed support for the provisions in §155.1010(b) of the proposed rule related to the deemed certification of multi-State plans and emphasized the importance of creating a level playing field for all QHPs within an Exchange. Several commenters recommended that the final rule clarify that multi-State plans and CO-OPs will be treated identically to other plans; for example, multi-State plans and CO-OPs would comply

with any additional certification criteria established by an Exchange, and could be excluded in States that selectively contract.

Response: The final rule establishing the CO-OP program, "Patient Protection and Affordable Care Act; Establishment of Consumer Operated and Oriented Plan (CO-OP) Program," published at 76 FR 77392 (December 13, 2011) directs CO-OPs to comply with all standards generally applicable to QHP issuers. We anticipate that specific standards for multi-State plans will be described in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act.

We note that the Affordable Care Act specifically provides a deeming process for multi-State plans and CO-OPs. Based on this fact, we do not believe these plans can be excluded from participation, including in Exchanges that adopt selective certification approaches.

Comment: Several commenters supported flexibility for States to establish a certification timeline for QHPs, as provided in proposed §155.1010(c). In contrast, some commenters recommended that the final rule specify a certification timeline or suggested specific times by which health plans must be certified as QHPs, such as 10 months prior to the beginning of the relevant open enrollment period.

Response: In developing the certification timeframe, an Exchange may need to consider market conditions in the State, including the potential for participation by new QHP issuers. As a result, we are not establishing a specific deadline by which an Exchange must complete certification, other than that certification must be completed prior to the open enrollment period for those QHPs that will be made available during open enrollment. We have revised the regulation text by replacing the proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open

enrollment period must be certified before the beginning of such period. We encourage Exchanges to certify QHPs before the open enrollment period to the extent possible, and to consider the needs of consumers, issuers, and other stakeholders when establishing certification timelines.

Comment: Multiple commenters requested clarification as to how Exchanges will continually monitor compliance with certification standards as described in proposed §155.1010(d). Several commenters offered specific recommendations related to ongoing monitoring, including that HHS establish a national complaint tracking database; that QHPs demonstrate compliance rather than placing the burden of proof on Exchanges; that HHS establish penalties for non-compliance; and that Exchanges consider network adequacy and provider payment practices.

Response: The Exchange is generally responsible for monitoring ongoing QHP compliance with certification standards. There are existing and variable mechanisms for monitoring health plan performance; therefore, we believe Exchanges are best positioned to develop a process and infrastructure for monitoring QHP performance in the Exchange. This could include coordination with State departments of insurance, reviews of health plan performance, and other approaches. We note that the final rule gives Exchanges the express authority to decertify a QHP at any time for non-compliance with certification standards, including the discretion to establish sanctions for non-compliance.

Comment: Several commenters requested that the final rule clarify whether a multi-State plan may cover non-excepted abortion services if its service area includes one or more States where coverage of such services is prohibited by State law.

Response: Specific standards for multi-State plans will be described in future rulemaking published by OPM in accordance with section 1334 of the Affordable Care Act.

Comment: A few commenters requested that Exchanges be permitted to contract with other State agencies, such as the State department of insurance, to certify, recertify, and decertify QHPs for participation in the Exchange.

Response: Exchanges may enter into agreements with eligible entities in accordance with §155.110, including other State agencies, to perform Exchange functions such as QHP certification. The Exchange is responsible for establishing processes for QHP certification, recertification, and decertification. The Exchange may choose to carry out these functions by contracting with the State department of insurance or another appropriate entity, but must retain ultimate accountability for the certification and review of QHPs in accordance with §155.110.

Comment: A few commenters addressed the certification processes for the individual Exchange and SHOP under proposed §155.1010(a). While some commenters recommended that the certification process be identical for both Exchanges, others supported two distinct processes in States where the individual Exchange and SHOP are separately administered.

Response: The administrative structure of the individual Exchange and SHOP may vary by State. Further, the final rule offers significant flexibility to Exchanges in designing the certification process and does not prescribe a particular approach. Therefore, the final rule neither prescribes a single, uniform process nor two complementary processes for certification.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1010 of the proposed rule, with the following modifications: we redesignated proposed paragraphs (c) and (d) as final paragraphs (a)(1) and (a)(2) to clarify that the certification timeline and the direction for Exchanges to

monitor QHPs for ongoing compliance are considered part of the certification process. In paragraph (a)(1), we added language to increase flexibility for an Exchange to certify a QHP during the benefit year by replacing the proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open enrollment period must be certified before the beginning of such period. We revised the language in paragraph (b) to clarify that both multi-State plans and CO-OPs must be recognized by the Exchange as certified (we have previously finalized that Exchanges must recognize CO-OP QHPs in 45 C.F.R. §156.520(e)(1), published at 76 FR 77414).

c. QHP issuer rate and benefit information (§155.1020)

In §155.1020, we proposed that Exchanges must receive a QHP issuer's justification for a rate increase prior to the implementation of such an increase, and ensure that the QHP issuer posts the justification on its Web site. Specifically, we proposed to codify the statutory direction in section 1311(e)(2) of the Affordable Care Act that an Exchange consider the following factors related to health plan rates when determining whether to certify QHPs: (1) the justification of a rate increase prior to the implementation of the increase; (2) the recommendations provided to the Exchange by the State under section 2794(b)(1)(B) of the PHS Act; and (3) any excess rate growth outside the Exchange as compared to the rate of growth inside the Exchange, including information reported by the States. We also solicited comment on how to best align section 2794 of the PHS Act and section 1311(e)(2) of the Affordable Care Act with respect to review of rates. Finally, we proposed that the Exchange must, at least annually, receive from QHP issuers information on rates, covered benefits, and cost sharing for each QHP, in a form and manner specified by HHS.

Comment: Many commenters expressed support for the standard in proposed §155.1020(a) that an Exchange ensure that any rate increase justification is prominently posted on the QHP issuer's Web site. Several commenters requested clarification of the meaning of "prominently" posted or made specific recommendations that, for example, the Exchange Web site link to the justification on the issuer's Web site, that the Exchange Web site separately post the justification, or that the Exchange Web site include a pop-up "warning" to enrollees who select a QHP for which there was a recent rate increase.

Response: In the final rule, we have amended §155.1020(a) to direct the Exchange to provide access to the rate increase justification posted on the issuer's Web site. We believe that this additional standard would provide greater transparency, and make it easier for consumers to access information about rate increases when considering QHPs. We note that nothing in this final rule would preclude an Exchange from separately posting an issuer's justification or otherwise informing consumers about rate increase justifications, as suggested by commenters.

Comment: A few commenters recommended that the final rule specify that the Exchange must collect rate justifications in accordance with proposed §155.1020(a) in a timely manner.

Response: The Exchange must collect rate justifications in advance of the annual certification or recertification process, so that the Exchange can meaningfully consider the information when determining whether to make a QHP available through the Exchange. This is implicit in the operation of §155.1010 and §155.1020. However, recognizing that Exchanges may establish different timelines for certification and recertification within the parameters described in §155.1010, we do not establish a separate uniform date for the collection of such justifications in the final rule.

Comment: One commenter requested that HHS clarify that any discussion of the State Insurance Commissioner or State department of insurance in the preamble to the proposed rule encompasses any relevant State regulator.

Response: While the statute gives the Exchange this authority, we believe that that the intent of §155.1020 is that the Exchange consider recommendations from the State agency or official responsible for complying with section 2794(b) of the PHS Act.

Comment: Many commenters suggested ways Exchanges could consider rate increase justifications under proposed §155.1020(b). Some commenters favored a rigorous rate review process that would go beyond the functions currently performed by State regulators, such as by collecting additional information from QHP issuers implementing rate increases (for example, evidence of efforts to control costs through value-based benefit designs).

In contrast, several other commenters recommended that the final rule reaffirm the traditional role of States in reviewing rates. Commenters further urged HHS to minimize the potential for duplication and inconsistency by encouraging the Exchange to leverage a State's program under section 2794 of the PHS Act to review rates. One commenter requested that the final rule clarify that an Exchange's ability to act in response to a rate increase would be limited to deciding whether to make a QHP available through the Exchange.

Response: We encourage the Exchange to leverage existing State rate review processes to the extent appropriate. As we highlighted in the preamble to the proposed rule, such coordination could include posting or adopting the same format used for rate justifications submitted to the State. However, we note that in some cases an Exchange may engage in more in-depth consideration of QHP issuers' justifications when determining whether to make a QHP available on the Exchange. As a result, we do not limit the ability of Exchanges to conduct additional

reviews of rate increase justifications, although we recommend that Exchanges consider the administrative burden on issuers associated with any such reviews. We note that an Exchange's consideration of rate increases is limited to whether a QHP should be made available on the Exchange.

Comment: In response to the provision in proposed §155.1020(b) that an Exchange consider rate increases, many commenters requested that HHS clarify how the Exchange must incorporate such review into the QHP certification process. A few commenters recommended that excessive rate increases be considered cause for refusal of certification or decertification. Conversely, one commenter recommended that Exchanges initially not consider rate increases in the certification of QHPs, and that in later years the level or review would be proportional to the size of the rate increase. Finally, a few commenters requested that the final rule clarify how HHS will oversee Exchange review of rate increases.

Response: An Exchange may choose from a variety of approaches with respect to QHP issuer rate increases. For example, an Exchange may exercise the discretion provided in §155.1000(c)(2) by opting to not make available QHPs implementing rate increases that the Exchange determines are not sufficiently justified. Other Exchanges may choose to rely more heavily on the process and determinations made by the applicable State regulator. Therefore, we are not prescribing a specific process or standard that the Exchange must follow in its consideration of rate increase justifications in this final rule.

Comment: One commenter requested that the final rule clarify the applicability of the provisions in this section to multi-State plans.

Response: Standards and processes related to multi-State plans will be addressed in future rulemaking by OPM in accordance with section 1334 of the Affordable Care Act. Because

OPM will administer contracts with multi-State plans, we anticipate that OPM may collect certain data, including rate and benefit data, from multi-State plans. To avoid duplicate reporting and minimize administrative burden, we have amended proposed §155.1020(b) and (c) to clarify that OPM will provide a process for rate increase consideration of multi-State plans and a process for multi-State plans to submit rate and benefit information, respectively.

Comment: Two commenters requested the meaning of the standard in proposed §155.1020(b)(1)(iii) that an Exchange consider any excess of rate growth outside versus inside the Exchange. One commenter requested clarification of whether HHS will establish a uniform, national limit on rate increases. Another commenter requested that HHS clarify the meaning of premium price controls. One commenter recommended that the final rule discourage or prohibit the Exchanges from holding down rates and creating "spillover" increases outside the Exchange or in other States, for multi-State plans. Finally, one commenter recommended that the rate review function inside and outside of the Exchange be combined.

Response: As indicated in the preamble to the proposed rule, we encourage Exchanges to work closely with State departments of insurance when considering issuer rate increases. With respect to §155.1020(b)(1)(iii), we note that an Exchange should consider the rate of growth in rates for similar products that are offered outside versus inside the Exchange, which may help the Exchange in its consideration of rate increase justifications.

The term premium price controls is not defined in section 1311(e) of the Affordable Care Act, which this provision implements. We note that review of rate information in accordance with this section is the responsibility of the Exchange; therefore, we are not defining the term "premium price controls" or setting a national limit in this final rule.

Comment: A few commenters requested that the final rule clarify the content and timing of reporting of the rate and benefit information described in proposed §155.1020(c). One commenter recommended that the information be reported twice per year. Several commenters urged HHS to direct the Exchange also collect information on benefit exclusions.

Response: We intend to clarify the format and content of data submission in accordance with this section in future guidance. Because the purpose of the collected information is to support the QHP certification process, the timing is implicit in the operation of this provision in conjunction with §155.1010(a). We note that we interpret §155.1020(c)(1) to direct Exchanges to collect rate information for pediatric dental benefits offered in accordance with section 1302(b)(1)(J) of the Affordable Care Act, and for any benefits in excess of the other benefits offered under section 1302(b) of the Affordable Care Act. Exchanges will need to be able to identify such information to support the administration of advance payments of the premium tax credit.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1020 of the proposed rule, with a few exceptions. In paragraph (a), we added that the Exchange must provide access to rate justification information on its Internet Web site. We also clarified throughout this section that the U.S. Office of Personnel Management will determine the process by which OPM will consider rate increases and by which multi-State plans submit rate and benefit information to the Exchange.

d. Transparency in coverage (§155.1040)

In §155.1040, we proposed how section 1311(e)(3) would be implemented: that Exchanges direct health plans seeking certification as QHPs to submit transparency information

outlined in §156.220 to the Exchange, HHS, and other entities. We also proposed to direct the Exchange to monitor the use of plain language by QHP issuers when making available QHP transparency data, consistent with guidance developed jointly by the Secretary of HHS and the Secretary of Labor. In addition, we proposed that the Exchange direct QHP issuers to make cost-sharing information available to enrollees.

Comment: With respect to proposed §155.1040(a), several commenters recommended that Exchanges serve as data aggregators for transparency information. One commenter requested that Exchanges be permitted to contract with other entities to collect and analyze transparency data.

Response: While we believe some Exchanges may wish to aggregate transparency data across QHPs to facilitate the comparison of plans, other Exchanges may prefer not to take on this function, and others may contract with another entity to collect and analyze transparency data consistent with §155.110. Regardless, by law, we note that the Exchange must condition certification of a QHP on its submission of such transparency data in accordance with §156.220.

Comment: A few commenters recommended that HHS consult with consumers and other stakeholders in developing plain language guidance in accordance with proposed §155.1040(b). Other commenters suggested specific elements to include (for example, translation services). One commenter recommended that QHP issuers be permitted to attest to the use of plain language to reduce the administrative burden on the Exchange.

Response: We note that "plain language" is defined in §155.20. HHS and the Department of Labor will jointly develop and issue guidance on best practices of plain language writing, and will inform the public about the process for developing such guidance.

Comment: Several commenters recommended that the Exchange Web site inform consumers of their ability to request cost-sharing information from QHP issuers in accordance with proposed §155.1040(c) of this section.

Response: We will consider including sample language to this effect in the Exchange Web site template.

Comment: Multiple commenters requested that HHS clarify the oversight and enforcement process for data reporting in accordance with proposed §155.1040(a), including by specifying any sanctions that the Exchange may impose on QHP issuers for failure to report the data. One commenter specifically recommended that QHP issuers be directed to prepare compliance reports addressing transparency data and consumer inquiries regarding cost sharing.

Response: We expect that each Exchange will develop a compliance and enforcement approach that will apply to this and other certification standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1040 of the proposed rule, with the following modification: in paragraph (a) we clarified that the U.S. Office of Personnel Management will determine the process through which multi-State plans submit transparency data.

e. Accreditation timeline (§155.1045)

In §155.1045, we proposed that the Exchange establish the time period within which any QHP issuer that is not already accredited must become accredited following certification of a QHP. This provision is consistent with §156.275, in which we proposed that all QHP issuers must be accredited with respect to their QHPs within the timeframe established by the Exchange.

Comment: We received many comments in response to our proposed standard to allow

Exchanges to determine a uniform period following certification by which QHP issuers must be accredited. A number of commenters agreed with our proposal that the States should be given flexibility to determine this timeline. Several other commenters disagreed with our proposal to allow Exchanges to set the timeline for accreditation for QHPs and requested that HHS establish a Federal timeline for accreditation that all Exchanges must follow. Several commenters suggested appropriate accreditation timelines for HHS to establish. Another commenter suggested that allowing QHP certification without accreditation runs counter to the intent of the law and State autonomy in determining the accreditation timeline fails to offer adequate consumer protection.

Response: We maintain our regulation text as stated in the proposed rule. We believe that this proposal is consistent with our efforts to ensure that Exchanges have the discretion to implement QHP issuer standards that best meet the needs of their Exchange enrollees. To draw new issuers to the Exchange, we note that an Exchange may want to provide issuers with additional time beyond initial certification to become accredited. Section 1311(c)(1)(D)(ii) of the Affordable Care Act clearly provides for the Exchange to establish the timeframe.

Comment: We received a single comment to our proposed provision in §155.1045 requesting that plans be allowed to select their own accrediting entity. We also received a comment suggesting criteria that the Secretary should use to recognize accrediting entities.

Response: We expect to engage in future rulemaking to adopt a process and criteria for the recognition of accrediting entities.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1045 of the proposed rule with the clarification that the Office of Personnel Management will establish the accreditation period for

multi-State plans as part of the certification of those plans.

f. Establishment of Exchange network adequacy standards (§155.1050)

To ensure that Exchange network adequacy standards are appropriate for QHP issuers and reflect local patterns of care, we proposed in §155.1050 that each Exchange ensure that enrollees of QHPs have a sufficient choice of providers. We discussed, in preamble, different measures of network adequacy and solicited comment on whether the final rule should set Federal minimum network adequacy standards or direct the Exchanges to set specific types of standards, including additional qualitative or quantitative standards. We also requested comment on an additional standard that the Exchange ensure that QHPs' provider networks provide sufficient access to care for all enrollees, including those in medically underserved areas.

Comment: A few commenters requested that HHS clarify how the network adequacy standards will be monitored and enforced. Commenters recommended that the Exchange report on oversight of network adequacy, or use specific tactics to monitor network adequacy (for example, secret shopper events, monitoring of appointment wait times).

Response: Many States direct health insurance issuers to evaluate the adequacy of their provider networks on an ongoing basis and monitor network adequacy in their traditional role of regulating health insurance. We encourage Exchanges to coordinate with State departments of insurance in monitoring QHP networks for sufficient access, and this final rule provides Exchanges with discretion to establish their own monitoring procedures to assure ongoing compliance. We anticipate that Exchanges will identify a variety of tools and strategies to monitor QHP compliance with all certification standards, including standards related to network adequacy. Accordingly, we are not prescribing specific oversight and enforcement strategies in this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1050 of the proposed rule, except that we are revising the regulation text to clarify that an Exchange must ensure that each QHP complies with network adequacy standards established in accordance with §156.230.We are reorganizing the regulation text for increased clarity and flow by moving the network adequacy standard to §156.230. In addition, the regulation text is revised to clarify that the U.S. Office of Personnel Management will ensure compliance with network adequacy standards for multi-State plans as part of the certification of those plans. Finally, for reasons described in §156.230, we clarified that a QHP issuer may not be prohibited from contracting with any essential community provider. For a complete discussion of the comments on network adequacy standards, please refer to §156.230.

g. Service area of a QHP (§155.1055)

In §155.1055, we proposed that Exchanges have a process to establish or evaluate the service areas of QHPs to determine whether the following criteria are met: (1) The service area covers a minimum geographical area that meets certain conditions, and (2) has been established without regard to racial, ethnic, language, health status-related factors listed in section 2705(a) of the PHS Act, or other factors that exclude specific high utilizing, high cost, or medically-underserved populations.

Comment: Many commenters supported the service area standard in proposed §155.1055(a). However, several commenters recommended alternative standards, such as that all QHPs must serve the entire Exchange service area, the entire State, areas smaller than a county, or contiguous areas. Some commenters suggested that HHS refrain from requiring QHPs to offer coverage Statewide to ensure that local health plans may participate, while others encouraged

Exchanges to align standards with market-wide standards.

Response: Under the proposed and final rule policy, Exchanges have the ability to establish or evaluate QHP service areas in such a way that would allow for participation by local health plans, provided that such standard is established without regard to the factors listed in §155.1055(b). We recommend that Exchanges consider aligning QHP service areas with rating areas established by the State in accordance with section 2701(a)(2) of the PHS Act. To the extent QHPs operate within such uniform service areas, this policy would facilitate consumers' ability to compare premiums of QHPs, promoting competition within the Exchange market. Furthermore, aligning QHP service areas with rating areas may simplify consumer understanding and Exchange administration of eligibility determinations for premium tax credits, which may be complex if QHP service areas are highly individualized.

Comment: Several commenters expressed concern that allowing Exchanges to set unique service area standards would conflict with existing State standards that are meant to prevent against discriminatory service areas.

Response: We acknowledge that some States already have in place service area standards that protect against red-lining and other "cherry-picking" practices where the issuer only offers plans to geographic areas that are expected to have lower risk. We believe that §155.1055 of this final rule provides a sufficiently broad standard such that an Exchange operating in a State with equally or more protective service area standards that prevent discrimination could use those standards for QHP issuers as well. To the extent that the broad standard here is more protective than existing State law, however, the Exchange must apply this regulatory standard to QHPs.

Comment: One commenter requested examples of the "necessary" or "nondiscriminatory" standards in proposed §155.1055(b). Another commenter suggested that the

Medicare Advantage precedent would be useful in determining whether service of part of a county would fall under necessary or non-discriminatory standards. Two commenters suggested that HHS specifically incorporate the parameters relating to a small geographic service area contained in the Medicare manual.

Response: We believe that the Medicare Advantage "county integrity rule" described in 42 CFR 422.2 (defining service area) is a useful resource for evaluating service areas, and we noted in the preamble to the proposed rule that the service area standard in §155.1055 mirrors the standard established by Medicare Advantage (76 FR 41866, at 41894 (July 15, 2011)). While we believe that the standards set forth by Medicare Advantage guidance provide examples of how to apply this standard, we note that States have discretion to interpret "necessary, non-discriminatory, and in the best interest of qualified individuals and qualified employers." For example, if a State has an existing service area standard that ensures service areas are not discriminatory and are in the best of the consumer, then the Exchange could decide to establish its service areas to be the same as the existing State standard. However, this provision provides authority for an Exchange to set stricter QHP standards if it observes service areas that specifically exclude certain areas.

Comment: A number of commenters requested clarification on the difference between a service area and a rating area.

Response: A rating area, as described in §156.255(a) and section 2701(a)(2) of the PHS Act, is a geographic area established by a State that provides boundaries by which issuers can adjust premiums in accordance with section 2701(a)(1)(A)(ii) of the PHS Act. In contrast, a service area is the geographic area in which an individual must reside or be employed (in accordance with standards outlined in §155.305 and §155.710) in order to enroll in a given QHP.

As noted previously, we recommend that Exchanges consider aligning QHP service areas with rating areas to foster competition, promote consumer understanding, and reduce administrative complexity.

Comment: One commenter recommended that HHS encourage States to establish service areas in accordance with proposed §155.1055 as soon as possible using county or other existing area boundaries, noting that new regional boundaries will increase administrative and logistical complexity of assembling a provider network.

Response: QHP issuers will need to understand QHP standards as early as practicable, and we encourage Exchanges to be transparent and clear about standards as far in advance of QHP certification as possible. As noted above, Exchanges do not need to establish new service area boundaries if existing service areas are not discriminatory.

Comment: Several commenters voiced concern about the lack of an overarching standard that Exchanges ensure a sufficient number of health plans in all geographic areas of an Exchange.

Response: In general, we clarify that the expectation of §155.105(b)(3) is that, to the extent possible, an Exchange must ensure that QHPs are available throughout the entire State. We encourage Exchanges to establish or negotiate service areas with QHP issuers to ensure that residents living in the Exchange service area have access to QHPs.

Comment: A few commenters suggested that the final rule specifically establish that service areas of QHPs cannot be drawn to avoid dividing Tribal communities and reservations, or former reservations, into different service areas.

Response: We note that §155.1055(b) establishes that QHP service areas be established in a non-discriminatory manner. We encourage the Exchange to consider the impact of QHP

service areas on Tribal communities when evaluating or developing service areas and to initiate Tribal consultation in connection with these issues.

Comment: A few commenters recommended the final rule add "economic factors" to the list of factors by which a QHP issuer cannot establish service areas in proposed §155.1055(b). Another set of commenters were concerned that the proposed rule only prevented discriminatory service areas within counties, but not between counties.

Response: We believe that this provision adequately addresses the underlying causes of "red-lining," which is to exclude populations that are high utilizing, high cost, or medically-underserved. In addition, while §155.1055(a) addresses discriminatory service area practices within a county, §155.1055(b) establishes that the general service area delineations must be established without regard to a variety of factors that could be used to "cherry-pick" healthy from unhealthy risk by geography.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1055 of the proposed rule with a modification to strengthen the language that directs Exchanges to ensure that the service area standards are met.

h. Stand-alone dental plans (§155.1065)

In §155.1065, we proposed that an Exchange allow limited scope stand-alone dental plans to be offered as stand-alone plans or in conjunction with a QHP, provided that the plans furnish at least the pediatric essential dental benefit described under section 1302(b)(1)(j) of the Affordable Care Act. We also proposed that the stand-alone dental plan comply with section 9832(c)(2)(A) of the Code and section 2791(c)(2)(A) of the PHS Act. We also proposed to allow an Exchange to certify a health plan as a QHP if it does not offer the pediatric essential

dental benefit, provided that a stand-alone dental plan is offered through the Exchange.

We requested comment on whether some of the QHP certification standards and consumer protections, such as a network adequacy, should also apply to stand-alone dental plans as a Federal minimum and what limits Exchanges may face on placing certification standards on dental plans given that they are excepted benefits. We also invited comment on whether we should set specific operational minimum standards related to allocation of advance payments of the premium tax credit, calculating actuarial value, and ensuring the availability of pediatric dental coverage in the Exchange. Lastly, in response to comments to the RFC, we requested comment on whether we should establish that all dental benefits must be offered and priced separately from medical coverage, even when offered by the same QHP issuer.

Comment: With respect to proposed §155.1065(b), one commenter interpreted section 1311(d)(2)(B)(ii) of the Affordable Care Act to mean that an Exchange must allow a stand-alone dental plan to offer coverage in an Exchange. The commenter requested clarification on whether the partnering of a QHP with stand-alone dental plans as their subcontractors for pediatric dental care would be consistent with this provision.

Response: We interpret the phrase regarding the offering of stand-alone dental plans "either separately or in conjunction with a QHP" to mean that the Exchange must allow stand-alone dental plans to be offered either independently from a QHP or as a subcontractor of a QHP issuer, but cannot limit participation of stand-alone dental products in the Exchange to only one of these options.

Comment: A number of commenters expressed concern regarding the applicability of cost-sharing limits and annual and lifetime limits to stand-alone dental plans. Commenters requested clarity on whether such limits applied, and cautioned that if stand-alone dental plans

do not have to comply with the same out-of-pocket, annual, and lifetime limit standards that would apply QHPs, then there would be an unlevel playing field.

Response: We accept the recommendation of commenters that cost-sharing limits and the restrictions on annual and lifetime limits should apply to stand-alone dental plans for coverage of the pediatric dental essential health benefit. The Affordable Care Act directs any issuer that must meet the coverage standards in section 1302(a) to cover each of the ten categories; thus, any issuer covering pediatric dental services as part of the essential health benefits must do so without annual or lifetime limits as defined under the Affordable Care Act and its implementing guidance, even if such issuers are otherwise exempt from the provisions of Subparts I and II of Part A of Title XXVII of the PHS Act (including PHS Act section 2711) under PHS Act section 2722. We note that for any benefit offered by a stand-alone dental plan beyond those established under section 1302(b)(1)(J) of the Affordable Care Act, standards specific to the essential health benefits would not apply. We plan to provide more detail in the future regarding how a separately offered pediatric dental essential health benefit would be considered under standards that apply to a full set of essential health benefits.

Comment: With respect to proposed §155.1065(b), several commenters specifically recommended that stand-alone dental plans be directed to offer a child-only pediatric dental plan. The commenters were concerned that an Exchange with only family dental coverage options and QHPs that do not have to cover the pediatric dental benefit would decrease the enrollment of children in dental coverage, as the advance payment of the premium tax credit would only be applicable to the pediatric dental essential health benefit. Others were concerned that the stand-alone dental plans would not have capacity to cover all potential enrollees which, combined with

the exemption for QHPs to not offer the pediatric dental coverage when stand-alone dental plans are available, would create insufficient access to child-only options.

Response: In this final rule, §155.1065(a)(3) would apply the standard of §156.200(c)(2) to offer child-only plan to stand-alone dental plans certified to be offered through the Exchange. In the new paragraph §155.1065(d), we direct an Exchange to consider the collective capacity of stand-alone dental plans during certification to ensure sufficient access to pediatric dental coverage. By "sufficient access," we mean to convey that Exchanges should ensure that, when combined, stand-alone dental plans have the capacity (in terms of solvency and provider network) to provide child-only coverage to all potential children enrolling in coverage through the Exchange.

Comment: A set of commenters addressed the request for comment in the proposed rule on whether the final rule should establish that QHPs must separately offer and price coverage for the pediatric dental essential health benefit so that consumers have the potential to enroll in dental coverage that is different from the dental benefits offered by the QHP they selected. Some suggested a standard for QHPs to separately price and offer pediatric dental coverage so consumers could make direct comparisons based on premium, cost-sharing, and benefits. Other commenters stated that it would be easier for consumers if the benefits were bundled. A number of commenters also recommended that HHS direct QHPs to offer medical-only options without pediatric dental coverage.

Response: If an Exchange determines that having QHPs separately offer and price pediatric dental coverage is in the interest of the consumer, as described in §155.1000(c), then the Exchange may establish such standard that as a condition of QHP certification. Otherwise,

QHPs are not uniformly directed to separately price and offer pediatric dental coverage under this final rule.

Comment: A few commenters urged HHS to allow health plans outside of the Exchange to have the same exemption as QHPs inside the Exchange, in that health plans would not have to cover pediatric dental if a stand-alone plan existed in the market.

Response: This request is outside the scope of this final rule, which addresses explicitly the standards for QHPs. Section 1302(b)(4)(F) of the Affordable Care Act specifically addresses the exemption in terms of QHPs offered through an Exchange.

Comment: With respect to proposed §155.1065(b), a small number of commenters requested that Exchanges ensure that stand-alone dental plans are offered as both fee-for-service plans and managed care plans.

Response: Section 1311(e)(1)(B)(i) prohibits the Exchange from excluding a plan from the Exchange because it is a fee-for-service plan.

Comment: Several commenters suggested that a way to indicate to QHPs that they will not have to cover pediatric dental coverage would be to issue a request for proposals to stand-alone dental plans in advance of the QHP certification process.

Response: We have not set any operational standards in §155.1065. Each Exchange has discretion in determining how to implement this provision.

Comment: With respect to proposed §155.1065(c), many commenters voiced support for allowing an Exchange to direct issuers of stand-alone dental plans to comply with any QHP certification standards and consumer protections, with some specifying network adequacy and cost-sharing standards. Many commenters stated that certification standards are necessary to ensure a level playing field between pediatric dental coverage offered through QHPs or stand-

alone products. A few commenters requested that HHS direct Exchanges to establish uniform certification and recertification standards for medical and stand-alone dental plans. A small number of commenters recommended that HHS not establish standards for stand-alone dental plans, or specified certain standards that should not apply, such as quality and accreditation. One commenter suggested that QHP issuers not have to comply with any standard that does not apply to stand-alone dental plans for the offering of pediatric dental coverage.

Response: We are persuaded by comments suggesting that stand-alone dental plans comply with QHP certification standards, as such standards will help ensure a consistent level of consumer protections as QHPs. Accordingly, we have added a new provision to §155.1065(a)(3) establishing that stand-alone dental plans must comply with QHP certification standards, except for those certification standards that cannot be met because the stand-alone dental plans covers only pediatric dental benefits. For example, to the extent that accreditation standards specific to stand-alone dental plans do not exist, such plans would not have to meet §155.1045. We also note that the Exchange may establish certification standards that are specific to the unique nature of stand-alone dental plans. For example, an Exchange can set a different network adequacy standard for stand-alone dental plans than for medical plans. For the purposes of this provision, any application of QHP standards to stand-alone dental plans by the Exchange would only apply to stand-alone dental plans offered through the Exchange.

Comment: A small number of commenters sought clarification on whether stand-alone vision plans could be offered through the Exchanges. Other commenters also sought clarification about the offering of other types of insurance that are not health plans, such as disability insurance.

Response: HHS is still evaluating this issue and plans to provide more details regarding the offering other coverage through an Exchange in future guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1065 of the proposed rule, with three modifications: in paragraph (a)(2), we clarify that section 2711 of the PHS Act would apply to the pediatric dental essential health benefit covered by a stand-alone dental plan. In new paragraph (a)(3), we established that stand-alone dental plans must comply with all QHP certification standards subject to certain exceptions. In new paragraph (c) we directed Exchanges to consider whether stand-alone dental plans will provide sufficient access to the pediatric dental essential health benefit during certification of stand-alone dental plans. Finally, we redesignated proposed paragraph (c) as paragraph (d).

i. Recertification of QHPs (§155.1075)

In §155.1075, we proposed that the Exchange implement procedures for the recertification of health plans as QHPs that include a review of the general certification criteria outlined in §155.1000(c). We also proposed to permit the Exchange to determine the frequency for recertifying QHPs. We invited comment on whether we should outline specific standards associated with the term length for recertification. In addition, we proposed that, after reviewing all relevant information and determining whether to recertify a QHP, the Exchange must notify a QHP issuer of its recertification status and take appropriate action. Finally, we solicited comments on the appropriateness of the proposed recertification deadline of September 15 of the applicable calendar year.

Comment: With respect to the recertification process described in proposed §155.1075(a), many commenters provided feedback on our proposal to permit Exchanges to

establish the frequency of recertification. While some commenters supported the flexibility provided in the proposed rule, others recommended that HHS establish the frequency for recertification and offered specific recommendations about the recertification interval, such as every one year, three years, or as-needed based on certain "triggering" events.

Response: We believe that Exchanges are best positioned to establish the frequency of or other parameters for recertification that reflect local market conditions or existing State regulatory processes. We believe varying intervals for recertification and approaches could be appropriate in some circumstances, and therefore are not establishing a uniform frequency for recertification in this final rule.

Comment: Multiple commenters recommended that specific elements be considered during the recertification process described in proposed §155.1075(a), such as a QHP issuer's complaint history, sanctions imposed by State regulators, or interaction with tribes and/or American Indian/Alaska Native populations. Commenters also suggested that the recertification process include a review of the QHP's network and engagement with essential community providers.

Response: An Exchange must establish a recertification process that includes a review of the minimum certification criteria outlined in §155.1000(c) of the final rule, and must monitor QHPs for ongoing compliance with certification criteria, as specified in §155.1010(d). At its discretion, an Exchange may establish additional recertification criteria or review processes, if the Exchange believes such criteria will improve the consumer experience.

Comment: While some commenters supported the proposed recertification deadline of September 15$^{th}$ of the applicable calendar year as indicated in proposed §155.1075(b), others

recommended greater flexibility for States or an alternate deadline, such as August 15 of each year.

Response: Recertification should be completed, and the appropriate parties notified, in advance of the open enrollment period so that consumers, issuers, and Exchanges have sufficient time to prepare for and make decisions about the upcoming plan year. In the proposed rule, we set forth the dates for the initial and annual open enrollment periods. In this final rule, we believe it is also appropriate to establish the annual deadline for recertification. We believe that the proposed deadline of September 15th provides sufficient time for Exchanges and issuers to participate in a robust recertification process, and also ensures that consumers will be fully informed of their plan choices at the start of each open enrollment period. Therefore, we are finalizing the proposed recertification deadline of September 15th in this rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1075 of the proposed rule, except that in paragraph (a) we clarified that, consistent with the revisions to §155.1010, multi-State plans and CO-OPs are not subject to the Exchange recertification process.

j. Decertification of QHPs (§155.1080)

In §155.1080, we proposed that the Exchange implement procedures for the decertification of health plans as QHPs, which we defined as the termination by the Exchange of the certification status and offering of a QHP. We also proposed that the Exchange must establish an appeals process for health plans that have been decertified. We requested comments generally on the proposed decertification process and asked specifically whether there were other appropriate authorities that could assist Exchanges in the decertification process. Finally, we proposed that if a QHP is decertified, the Exchange must provide notice of the decertification to

parties who may be affected, including the QHP issuer, enrollees of the decertified QHP, HHS, and the State department of insurance.

Comment: With respect to the decertification process proposed in §155.1080(b), some commenters supported the flexibility given to Exchanges to design the decertification process in the proposed rule, while other commenters suggested specific approaches to decertification. A few commenters requested that the final rule identify "triggering events" for decertification, such as a determination that a QHP's network is inadequate; others requested that HHS provide additional clarification on when decertification would be appropriate.

Response: We continue to provide Exchanges discretion in designing the decertification process and making decertification decisions. The final rule establishes that an Exchange may decertify a QHP at any time for failure to comply with the minimum certification standards described in §155.1000(c), and any additional certification standards established by the Exchange. We believe that this flexibility is necessary to allow an Exchange to tailor its process for compliance and decertification to be appropriate for the market conditions in the State. The Exchange is responsible for establishing the decertification process, including the approach used to identify plans that are out of compliance with certification standards or the associated sanctions.

Comment: One commenter requested additional information on whether multi-State plans may be decertified through the process described in proposed §155.1080(b).

Response: The Affordable Care Act establishes a deeming process for multi-State plans; as a result, we clarify that multi-State plans are exempt from the Exchange's recertification and decertification processes.

Comment: Several commenters requested that HHS clarify the consequences of an Exchange's failure to decertify plans that are out of compliance with certification standards as described in proposed §155.1080(c), and recommended that Exchanges be directed to decertify non-compliant QHPs.

Response: QHPs with persistent or significant compliance issues should be decertified and removed from the Exchange; however, we recognize that Exchanges may, for example, wish to pursue intermediate sanctions for minor violations of certification standards that do not adversely impact consumers, so long as such actions are consistent with applicable law. While it is our expectation that an Exchange would decertify a QHP that is not compliant with certification standards or where the health and safety of an enrollee may be at-risk, this final rule permits Exchanges to explore a variety of oversight and enforcement strategies, up to and including decertification. We intend to address oversight of Exchanges through future implementation and rulemaking under section 1313 of the Affordable Care Act.

Comment: One commenter recommended that an Exchange be permitted to certify new plan(s) to replace decertified QHP(s) during the benefit or plan year in accordance with proposed §155.1080(c).

Response: We believe it is important for QHPs to be certified prior to the open enrollment period to ensure all consumers have the same plan options, and are aware of those options before they make their plan selections. However, we believe that an Exchange should have the option to replace a decertified QHP with another QHP in certain cases, for example if the decertification of a QHP resulted in no or few QHP choices in some regions of an Exchange's service area. We have revised the regulation text in §155.1010(a)(1) to provide additional flexibility for an Exchange to certify QHPs during the benefit year by replacing the

proposal that all QHPs must be certified before the beginning of the relevant open enrollment period with a standard that all QHPs offered during an open enrollment period must be certified before the beginning of such period.

Comment: A few commenters requested that the final rule clarify that QHPs decertified in accordance with proposed §155.1080(c) may retain non-Exchange membership.

Response: Decertification would not affect enrollees who purchased QHP coverage directly or not through the Exchange, because such members' enrollment occurred outside the Exchange. However, such a plan could no longer be marketed as a QHP following decertification and the population enrolled in that plan through the Exchange would be provided a special enrollment period to transfer to a different QHP in accordance with §155.420(d) and §155.430(b)(2)(iv). While the Exchange regulates enrollment through the Exchange, any sanctions or other actions related to a QHP's non-Exchange membership would be at the discretion of the State insurance commissioner.

Comment: A few commenters requested additional information on the appeals process described in proposed §155.1080(d) or suggested specific parameters, such as 30 days to file and 30 days to hear an appeal.

Response: Consistent with the authority to design the decertification process, the Exchange is responsible for outlining the parameters of the appeals process, including timing, what entity will hear appeals, and other factors.

Comment: Several commenters endorsed a special enrollment period for individuals whose QHP has been decertified under proposed §155.1080(c), and advocated that enrollees be permitted to change levels of coverage during such special enrollment period. One commenter recommended that consumers receive a special enrollment period if the QHP in which they are

enrolled appeals a decertification. One commenter recommended that enrollees be given 63 days to enroll in other coverage, while another suggested that coverage by the decertified QHP continue until enrollees make new plan selections.

Response: Enrollees would have an opportunity to select a new QHP once a QHP has been decertified. Allowing enrollees to switch plans in advance of a formal determination could create unnecessary disruption in the Exchange.

Consistent with §155.410, enrollees whose QHP is decertified would have access to a special enrollment period lasting 60 days from the date of the decertification. We believe that 60 days is a sufficient amount of time to select a new QHP. Finally, as described in the comment and response to §155.410, we are revising the regulation text to permit enrollees to change levels of coverage during a special enrollment period.

Comment: One commenter requested clarification on why HHS needs to receive information on decertified QHPs, as in proposed §155.1080(e)(3).

Response: HHS needs access to information on decertification of QHPs for a number of policy and operational reasons. For example, HHS will need to administer a termination of advance payments of the premium tax credit and payment of cost-sharing reductions to issuers of decertified QHPs.

Comment: Several commenters proposed standards for notices related to decertification and non-renewal identified in proposed §155.1080(e), such as that the notices be available in multiple languages, identify appropriate consumer resources, or include information targeted to specific populations such as American Indians and Alaska Natives. Alternatively, a few commenters recommended that HHS publish model notices. Finally, one commenter

recommended that the final rule direct Exchanges and QHP issuers to confirm receipt of notices related to decertification and non-renewal.

Response: Under this final rule, all notices to consumers issued by the Exchange must conform to the minimum standards outlined in §155.230, while notices issued by a QHP issuer must conform to standards established by §156.250. These include protections for individuals with limited English proficiency or disabilities, and establish that all notices be written in plain language. Further, to the extent that State law or Exchange policies provide for greater accessibility or additional content, an Exchange may provide notices that exceed the minimum standards in this final rule.

We believe that establishing a standard that Exchanges and QHP issuers confirm that each notice of decertification or non-renewal has been received by the appropriate enrollee would place a significant burden on Exchanges and issuers and could demand resources that are better used for other customer service functions. Further, we believe it is consistent with the current practices of many other programs to rely upon the contact information provided by each enrollee without confirming that each mailing has been successfully received.

Comment: One commenter requested that HHS clarify that in the case of a SHOP, each enrollee, and not each employer, must receive a notice of decertification or non-renewal described in proposed §155.1080(e), as appropriate.

Response: For purposes of SHOP, each enrollee must receive a notice of decertification or non-renewal. We note that §156.285(d)(1)(ii) directs QHP issuers offering QHPs through a SHOP to provide notices to both enrollees and qualified employers.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §155.1080 of the proposed rule, except that

in paragraph (b) we clarified that, consistent with the revisions to §155.1010, multi-State plans and CO-OPs are not subject to the Exchange decertification process.

B. Part 156 - Health Insurance Issuer Standards under the Affordable Care Act, Including Standards Related to Exchanges

Part 156 contains the proposed standards for QHPs and QHP issuers that are intended to promote robust and meaningful consumer choice.

1. Subpart A - General Provisions

a. Basis and scope (§156.10)

Proposed §156.10 of subpart A specified the general statutory authority for the ensuing regulation and noted that the scope of part 156 is to establish standards for health plans and health insurance issuers related to the benefit design standards and in regard to offering QHPs through an Exchange. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Definitions (§156.20)

Most of the terms that we proposed to define in this section refer to terms proposed in §155.20. Beyond these terms, we proposed that the term "benefit design standards" mean the "essential health benefits package" defined in section 1302(a) of the Affordable Care Act. We did not receive comments on this section that were not addressed elsewhere, and are finalizing the definitions as proposed.

c. Financial support (§156.50)

In §156.50, we proposed that participating issuers pay user fees to support ongoing operations of an Exchange, if a State chooses to impose such fees. We proposed to define the term "participating issuer" to mean an issuer offering plans that participate in the specific

function that is funded by the user fee. We further proposed that participating issuers pay any fees assessed by a State-based Exchange, consistent with Exchange authority outlined in §155.160.

Comment: Several commenters on proposed §156.50 recommended that HHS modify the definition of "participating issuer" by simplifying and broadening the proposed definition. Specifically, two commenters requested that HHS clarify whether the proposed definition would mean that Exchanges would charge user fees in proportion to an issuer's participation in specific Exchange functions.

Response: The definition proposed in §156.50 is structured to accommodate the variety of functions that an Exchange could perform. We note that the proposed definition does not direct an Exchange to pro-rate or otherwise tailor user fees to the specific functions in which an issuer participates. Rather, an Exchange could, but is not directed to, charge uniform user fees to all participating issuers. We note that the Affordable Care Act suggests user fees charged to participating issuers as a means for States to ensure that an Exchange is self-sustaining. We track that statutory language in this final rule when using the term participating issuer.

Comment: A few commenters recommended that §156.50(b) of the final rule clarify that participating issuers must pay all assessments established by an Exchange, whether structured as user fees or otherwise.

Response: We believe that participating issuers are responsible for paying any assessments established by an Exchange irrespective of how such assessments are structured. Therefore, we are revising the regulation text in §156.50 of this final rule to reflect this clarification.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.50 of the proposed rule, with the following modifications: in paragraph (b), we clarified that a participating issuer must remit user fees to a State-based or a Federally-facilitated Exchange. We further clarified in paragraph (b) that a QHP issuer must remit any fees charged by the Exchange in accordance with §155.160, whether structured as user fees or otherwise.

2. Subpart C - Qualified Health Plan Minimum Certification Standards

Section 1311(c)(1) of the Affordable Care Act authorizes the Secretary, by regulation, to establish criteria for the certification of health plans as QHPs; we implement that authority in this subpart. The proposed rule clarified that, unless otherwise noted, the standards for QHPs proposed in this subpart do not supersede existing State laws or regulations applicable to the health insurance market generally, apply specifically to the certification of QHPs for participation in the Exchange, and do not exempt health insurance issuers from any generally applicable State laws or regulations.

a. QHP issuer participation standards (§156.200)

In §156.200, we outline the proposed standards on QHP issuers as a condition of participation in the Exchange. These include: (1) complying with the standards in this subpart; (2) complying with the proposals established in accordance with subpart K of part 155, and in the small group market, §156.705; (3) ensuring that each QHP complies with the benefit design standards defined in §156.20; (4) being licensed and in good standing to offer health insurance in the State; (5) implementing and reporting on quality improvement strategies consistent with section 1311(g) of the Affordable Care Act; (6) paying applicable user fees; and (7) complying with standards related to risk adjustment under part 153. We noted that States may choose to establish additional conditions for participation beyond the minimum standards established by

the Secretary. We also proposed that 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 and that the issuer meets all applicable standards.

We also outlined the set of proposed standards with which a QHP issuer must comply related to the offering of a QHP, and specified that the QHP issuer must comply with the standards set forth in this subpart on an ongoing basis. The offering standards included: (1) offering at least one QHP in the silver and gold coverage level; (2) offering a child-only plan at the same level of coverage; and (3) offering the QHP at the same premium rate when the QHP is offered directly by the issuer or through an agent or broker (implemented through §156.255(b)). Finally, we proposed that a QHP issuer not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

Comment: Several commenters requested that HHS clarify the standard that a QHP issuer be in "good standing" to offer health insurance in proposed §156.200(b)(4). While many commenters supported the proposed provision as written, a few suggested that HHS strengthen the standard. Conversely, one commenter recommended that "in good standing" be defined to exclude minor violations. One commenter recommended that QHP issuers be held accountable for demonstrating good standing, such as by providing an attestation from the relevant State regulator.

Response: As described in the preamble to the proposed rule, we interpret "good standing" to mean that an issuer faces no outstanding sanctions imposed by a State's department of insurance. Therefore, the specific violations or infractions that would jeopardize standing may vary by State. With respect to determining licensure and standing, Exchanges may wish to use a number of means, such as attestation or verifying the information directly with State departments

of insurance. Accordingly, we do not prescribe a specific process in this final rule, but instead allow Exchanges discretion in determining the best way to substantiate licensure and standing.

Comment: Several commenters requested that HHS harmonize quality reporting standards in proposed §156.200(b)(5) with other public programs, suggested quality measures HHS could consider to evaluate QHPs, and made specific recommendations regarding both the quality improvement strategy and quality rating system. Commenters also requested that national quality standards be utilized and quality used as a factor in QHP certification decisions. Other commenters requested that quality information be publicly reported to consumers to inform QHP selection.

Response: We will provide additional detail on the content and manner of quality reporting under this section in future guidance.

Comment: In response to proposed §156.200(c)(1), one commenter recommended that plans be permitted to achieve the bronze level of coverage over time, while participating in an Exchange as a QHP.

Response: Section 1301(a)(1)(B) of the Affordable Care Act directs a QHP to provide the essential health benefits package, which includes compliance with the level of coverage standards outlined in section 1302; therefore, a health plan that does not meet the bronze level of coverage cannot be certified as a QHP and made available through the Exchange. HHS will issue future rulemaking on section 1302, but the Affordable Care Act does not provide for a transitional process to achieving the coverage levels.

Comment: Many commenters offered feedback on the standard for QHP issuers to offer a corresponding child-only plan for any QHP offered through the Exchange, described in proposed §156.200(c)(2). Several commenters recommended that HHS permit individuals up to age 26 to

enroll in child-only coverage; two commenters recommended that instead of offering a separate child-only plan, QHP issuers be directed or permitted to accept enrollees of any age into a QHP offered to single qualified applicants.

Response: Section 1302(f) of the Affordable Care Act directs a QHP issuer that offers a non-catastrophic plan on the Exchange to offer an identical child-only plan. We clarify that a QHP issuer could satisfy this standard by offering a single QHP to qualified applicants seeking child-only coverage, as long as the QHP includes rating for child-only coverage in accordance with applicable premium rating rules. Section 1302(f) further specifies that for purposes of this standard, a child-only plan is available to individuals under age 21 at the beginning of the benefit year. We lack the authority to alter the age limitation for enrollment into a child-only plan.

Comment: In response to this section, a few commenters requested that HHS confirm whether a QHP may contract with providers that serve specific populations, such as tribal health care providers, without violating the anti-discrimination provisions in proposed §156.200(e).

Response: The anti-discrimination provisions included in §156.200(e) are intended to protect enrollees and potential enrollees from discriminatory practices on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation. A QHP issuer may contract with health care providers that are authorized or directed by law to serve specific populations, such as Indian health providers, without violating these provisions. We note that a QHP issuer must meet all standards related to network adequacy and essential community providers specified in §156.230 and §156.235, respectively.

Comment: With respect to proposed §156.200 in general, several commenters recommended that certain issuers, such as Medicaid managed care organizations, church plans and union plans, be permitted to offer certified QHPs on a limited-issue basis.

Response: As established in section 1301(a) of the Affordable Care Act, all QHPs must be offered by licensed health insurance issuers that are subject to the guaranteed issue provisions, effective January 1, 2014. Under section 2702 of the PHS Act, these issuers must issue coverage to any individual who applies for coverage in a particular health plan. Though the statute allows issuers to stop accepting new enrollees to preserve financial solvency or due to provider network capacity under section 2702(c) and (d), respectively, the issuer must close off enrollment, or begin accepting new enrollees again, uniformly rather than selectively. We note that HHS will address the authority under 2702 under separate rulemaking.

We recognize the potential for significant movement of individuals between the Exchanges and Medicaid, as well as the potential for members of a family to be covered separately under the Exchange, Medicaid, and CHIP. We recognize that QHPs offered by Medicaid managed care organizations (MMCOs) may be able to play an important role in keeping family members covered under a common issuer and in the same provider network, promoting continuity of coverage, and mitigating the potential negative effects of "churning" between Medicaid and the Exchanges**.** HHS may provide additional guidance on this topic in the future. Additionally, we intend to address commenters' concerns surround multi-employer plans in future guidance.

Comment: A few commenters recommended that each Exchange include at least one QHP that is also a Medicaid MCO to minimize enrollee churn. A handful of commenters recommended that the Exchange be directed to deem Medicaid MCOs and other safety net health plans as QHPs. Similarly, one commenter recommended that safety net health plans be permitted to achieve licensure gradually while participating in the Exchange.

Response: Medicaid MCOs must meet the same standards as other plans to become QHPs. However, we note that Exchanges have discretion to develop specific certification criteria in a manner that might facilitate participation by Medicaid MCOs, including the establishment of the accreditation timeline as specified in §155.1045 and the setting of QHP service areas in §155.1055. We also note that there may be opportunities to leverage the Exchange Web site in a manner that would allow the Exchange to identify issuers that participate in both the Exchange and Medicaid managed care.

Comment: A few commenters requested that HHS clarify States' ability to develop additional certification and participation standards for QHPs.

Response: We clarify that nothing in this section precludes an Exchange from establishing additional certification criteria or issuer participation standards beyond those specified in the final rule if in the interest of qualified individuals and qualified employers served by the Exchange, per final §155.1000(c) and the preamble discussion for that section in this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.200 with the following modification: we have removed proposed paragraph (c)(3) related to offering a QHP at the same premium rate inside and outside of the Exchange to avoid duplication of §156.255(b).

b. QHP rate and benefit information (§156.210)

In §156.210, we proposed that a QHP's rates must be applicable for an entire benefit year or, for the SHOP, plan year. We also proposed that QHP issuers submit rate and benefit information to the Exchange and that a QHP issuer submit a justification for a rate increase prior to the implementation of such increase for purposes described more fully in §155.1020.

Additionally, we proposed that QHP issuers post rate increase justifications on their Web sites so they can be viewed by consumers, enrollees, and prospective enrollees.

Comment: Several commenters supported the provision in proposed §156.210(a) that QHP issuers set rates for an entire benefit or plan year. Conversely, some commenters recommended an exception for plans participating in the SHOP, or to accommodate Federal or State regulatory changes.

Response: All QHPs, including those participating in the SHOP, must offer a set rate for an entire benefit or plan year. We note that while QHP issuers in SHOP may establish new rates quarterly or annually, issuers must charge the same contract rate for a plan year. We note that most Federal and State regulatory changes are proposed well in advance of becoming effective, so the number of regulatory changes that would take effect in the middle of a benefit or plan year will be limited. Therefore, no exceptions are provided in the final rule.

Comment: One commenter recommended that QHP issuers notify enrollees in advance of any rate increase.

Response: The final rule strengthens the transparency standards regarding rate increases. In §155.1020, QHP issuers must submit to the Exchange a justification for a rate increase prior to the implementation of the rate increase. Potential and current enrollees will be able to compare QHPs and rates through the Exchange Web site. Accordingly, we are not adding an additional notice obligation to this section.

Comment: Several commenters offered feedback on the scope of the standard to post rate increase justifications in proposed §156.210(c). While some commenters recommended posting of all rate increases, others recommended that posting be limited to rate increases determined unreasonable by a State's program for the review of rates under section 2794 of the PHS Act.

Response: The Affordable Care Act, at section 1311(e), demands the posting of all rate increase justifications submitted by a QHP issuer. Therefore, §156.210(c) establishes that all rate increase justifications must be posted, irrespective of whether the increase is subject to review by a State's program under section 2794 of the PHS Act to determine if it is an unreasonable increase or the determination of such review. We continue to encourage Exchanges to leverage existing State processes, including a State's program under section 2794 of the PHS Act, to minimize the potential burden on QHP issuers associated with this section.

Comment: In response to the provision in proposed §156.210(c) that QHP issuers submit and post rate increase justifications, a few commenters recommended that HHS clarify that such justifications must be written in plain language and must not be deceptive.

Response: We encourage Exchanges to use the rate increase justifications submitted as part of the State's program under section 2794 of the PHS Act, because the format for these justifications were developed with input from the National Association of Insurance Commissioners and incorporates consumer-friendly language.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.210 of the proposed rule without modification.

c. Transparency in coverage (§156.220)

In §156.220, we proposed a transparency standard as a condition for certification of QHPs in accordance with section 1311(e)(3) of the Affordable Care Act. The proposed rule listed specific data elements that issuers must provide, from the Affordable Care Act: (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 enrollment rights under title I of the Affordable Care Act. We sought comment on whether QHP issuers should be directed to submit this information to the Exchange and other entities, or to make such information available to the Exchange and other entities. We also proposed that QHP issuers provide the specified information in plain language. Finally, we proposed that QHP issuers make available to the enrollee information on cost-sharing responsibilities for a specific service by a participating provider under that enrollee's particular plan.

Comment: Many groups commented on the data elements included in §156.220(a) of the proposed rule. Several commenters supported the proposed rule as written, with one commenter recommending that HHS maintain the list as proposed without additional elements. However, other commenters, suggested specific enhancements or clarifications to the proposed approach or requested that HHS establish uniform standards and methodologies. A few commenters recommended that HHS include reporting of additional data elements, such as information about condition-based exclusions. Some commenters requested that HHS provide sample forms, define key terms, or outline a specific reporting format (for example, a summary statement accompanied by data tables).

Other commenters recommended elements or approaches to transparency reporting, such as segmenting data by enrollee demographics, collecting information at the issuer level, or reporting at the product level. A few commenters provided recommendations on where transparency information should be submitted and where the information should be made available. One commenter encouraged HHS to apply the same standards to all plan types, including catastrophic plans. Several commenters recommended that HHS collect transparency

data annually. Finally, one commenter stated that these standards should be extended to Medicaid and CHIP populations.

Response: We believe that QHP issuers should submit transparency information in a manner and timeframe that maximizes the utility of such information to the Exchange, HHS, and individuals. HHS intends that the reporting obligations established in this section and §155.1040 will be aligned with the transparency reporting standards under section 2715A of the PHS Act. HHS, together with the Departments of Labor and the Treasury, will coordinate guidance on the transparency in coverage standards. As a result, we are not describing specific data formats, definitions, or frequency of reporting with respect to §155.1040 in this final rule. We note that data reporting for Medicaid and CHIP plans is outside the scope of this final rule.

Comment: Several commenters agreed with the plain language provision in proposed §156.220(c) as written. In addition, several commenters requested that HHS clarify how it will enforce plain language standards, with some expressing concern about the Exchange or HHS being able to check the accuracy of the plain language information submitted by QHP issuers. The commenters recommended that HHS direct QHP issuers to provide data with plain language information.

Response: We note that each Exchange will be responsible for ensuring QHP issuer compliance with this standard. HHS and the Department of Labor will jointly develop and issue guidance on best practices of plain language writing, which will assist Exchanges in determining whether issuers are using plain language, as defined in §155.20.

Comment: We received a number of comments supporting the cost-sharing transparency in proposed §156.220(d). Several commenters recommended that the provision be amended to allow the consumer to be able to request information by phone, fax, email, or online. One

commenter requested that HHS clarify whether the obligation to provide enrollee cost-sharing information is prospective or retrospective in nature. Several commenters recommended that HHS establish that the cost-sharing information be provided free of charge by QHP issuers to the enrollees.

Response: As noted previously, HHS will coordinate with the Departments of Labor and Treasury on guidance for the transparency in coverage standards.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.220 of the proposed rule without modification.

d. Marketing and Benefit Design of QHPs (§156.225)

To preserve a level playing field within and outside of the Exchange and to leverage existing State activities, we proposed in §156.225 that QHP issuers must to comply with any applicable State laws and regulations regarding marketing by health insurance issuers as a certification standard, as established by section 1311(c)(1)(A) of the Affordable Care Act. We also proposed to prohibit QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs and sought comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether such activities are taking place. Additionally, we invited comment on a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents, and representatives, and on whether HHS should establish a standard that QHP issuers not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP.

Comment: Many commenters offered feedback on whether the final rule should include a broad prohibition against deceptive marketing practices. A number of commenters supported

such a prohibition and suggested specific Federal standards that HHS could adopt, such as Medicare Advantage, Medicare Prescription Drug Program, or Medicaid standards. Conversely, many commenters supported State flexibility with respect to marketing rules and oversight. A few commenters expressed concern that a Federal standard could be overly restrictive.

Response: States have significant experience with, and existing infrastructure to support, monitoring and oversight of health plan marketing activities. The National Association of Insurance Commissioners (NAIC) has provided guidance to the States in the form of the Model Unfair Trade Practices Act. The Model Act has been adopted by 45 States and the District of Columbia. The NAIC has also issued an Advertisements of Accident and Sickness Insurance Model Regulation, which has been adopted by 42 States. Both the Model Act and Model Regulation are extensive and position States to address misleading or deceptive practices. As a result, we are finalizing the marketing standards with the flexibility afforded in the proposed rule.

Comment: Many commenters offered standards or clarifications for inclusion in proposed §156.225(b), such as a list of discriminatory versus acceptable marketing practices; a prohibition on inducements and other tactics prone to abuse; secret shopper events; focus group testing of marketing materials; and standardized compensation for agents and brokers in the Exchange.

Response: We note that the above tactics could be appropriately included in an Exchange's monitoring and oversight activities, as well as its marketing rules. While we are not establishing that an Exchange implement specific standards for the reasons described in the preceding response, we encourage Exchanges to consider a variety of standards, tools, and strategies to promote transparent and consumer-oriented conduct in the Exchange.

Comment: Many commenters urged HHS to codify the statutory prohibition against benefit designs that have the effect of discouraging enrollment of higher-need consumers in §156.225(b) of the final rule.

Response: We note that section 1311(c)(1)(A) specifically prohibits QHP issuers from utilizing benefit designs that have the effect of discouraging enrollment by higher-need individuals. We have modified §156.225(b) in this final rule to codify the statutory prohibition.

Comment: A few commenters recommended that the Exchange be permitted to decertify QHPs based on improper marketing practices.

Response: Section 155.1080 of the final rule gives the Exchange the authority to decertify a QHP at any time for failure to comply with certification standards, including standards related to marketing practices.

Comment: Several commenters recommended that HHS repeat the anti-discrimination standards established in §156.200(e) in this section.

Response: We believe that the broad prohibition on discrimination in §156.200(e) clearly bars discrimination in marketing practices as well as other operations of the QHP issuer, and that repeating this language in §156.225 is unnecessary.

Comment: Several commenters encouraged HHS to establish a level playing field with respect to marketing inside and outside of the Exchange. Specifically, a few commenters recommended that the final rule clarify that QHP issuers must comply with all State laws and regulations that govern marketing other health insurance products, such as statutes prohibiting unfair or deceptive acts or practices.

Response: We note that adopting the proposed rule's approach would ensure QHPs conform to any standards, laws, or regulations that govern the marketing of non-QHP health insurance products in a State.

Comment: Several commenters recommended that HHS direct Exchanges to report on oversight activities related to marketing. A few commenters additionally recommended that an Exchange Blueprint detail the Exchange's proposed approach to marketing oversight.

Response: Exchanges are responsible for ensuring compliance with the marketing standards of this section. States have significant experience in regulating marketing of health insurance issuers, and Exchanges may leverage the current monitoring practices of States with respect to marketing of health insurance. As a result, we are not imposing an additional reporting obligation for Exchanges in this area.

Comment: In response to the concern expressed in the proposed rule preamble that certain groups (for example, Medicare beneficiaries) may be vulnerable to deceptive marketing tactics, one commenter suggested that the Exchange electronically verify whether QHP enrollees are also enrolled in other coverage.

Response: We encourage Exchanges to develop a variety of strategies to identify improper marketing practices. We note that subpart D of this final rule provides for electronic verification of some types of other coverage in §155.320(b).

Comment: A handful of commenters recommended that HHS establish a mechanism to receive consumer complaints related to marketing practices.

Response: Consumers who encounter marketing practices that they believe are deceptive or improper should be able to report such practices to the Exchange or State regulator, as appropriate. Because the Exchange is responsible for monitoring marketing of QHPs and taking

any appropriate action, we believe that establishing a separate Federal complaint reporting mechanism is unnecessary.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.225 of the proposed rule, with the following modifications: in paragraph (b) we codified statutory language prohibiting QHP issuers from employing benefits designs that could discourage enrollment of individuals with significant health needs. Accordingly, we added "and Benefit Design" to the title of this section.

e. Network adequacy standards (§156.230)

In §156.230, we proposed the minimum criteria for network adequacy in order for health plans to be certified as QHPs. We proposed that QHP issuers meet network adequacy standards established by the Exchange in accordance with §155.1050 and consistent with the provisions of section 2702(c) of the PHS Act as amended by the Affordable Care Act. In the proposed rule, the network adequacy standard, stated in proposed §155.1050, established "sufficient choice of providers" as the touchstone of whether a provider network is adequate. The preamble discussion identified several different measures of network adequacy and sought comment on whether to include additional qualitative and quantitative standards to measure network adequacy.

We proposed that a QHP issuer make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request, and that the directory identify providers who are no longer accepting new patients. We sought comment on standards we might set to ensure that QHP issuers maintain up-to-date provider directories. We refer commenters to the summary of proposed §155.1050 in this final rule and to the preamble to the proposed rule for additional discussion of the proposed policy.

Comment: Many commenters offered feedback on the network adequacy standard, initially included in proposed §155.1050. Some commenters supported the flexibility provided to States in the proposed rule, noting that such flexibility could facilitate the alignment of markets inside and outside of the Exchange. Conversely, many commenters recommended that HHS establish a national, uniform standard for network adequacy. These commenters offered numerous standards HHS could adopt, including the NAIC Managed Care plan Network Adequacy Model Act, or the current standards for Medicare Advantage plans, Medicaid managed care plans, or TRICARE plans. Finally, a few commenters generally requested that HHS clarify the meaning of "sufficient number" of providers.

Response: A number of competing policy goals and considerations come into play with examinations of network adequacy: that QHPs must provide sufficient access to providers; that Exchanges should have discretion in how to ensure sufficient access; that a minimum standard in this regulation would provide consistent consumer protections nationwide; that network adequacy standards should reflect local geography, demographics, patterns of care, and market conditions; and that a standard in regulation could misalign standards inside and outside of the Exchange. In balancing these considerations, we have modified §156.230(a)(2) in this final rule to better align with the language used in the NAIC Model Act. Specifically, the final rule establishes a minimum standard that a QHP's provider network must maintain a network of a sufficient number and type of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be available without unreasonable delay. We believe this modification provides additional protection for consumers by communicating our expectations with respect to the number and variety of providers that should be present in a QHP's provider network. Further, the modified standard establishes a baseline ("all

services…without unreasonable delay") against which network adequacy can be measured. We note that nothing in the final rule limits an Exchange's ability to establish more rigorous standards for network adequacy. We also believe that this minimum standard allows sufficient discretion to Exchanges to structure network adequacy standards that are consistent with standards applied to plans outside the Exchange and are relevant to local conditions. Finally, placing the responsibility for compliance on QHP issuers, rather than directing the Exchange to develop standards, is more consistent with current State practice.

Comment: Several commenters urged HHS to codify the potential additional standards listed in the preamble to the proposed rule (access without unreasonable delay, reasonable proximity or providers to enrollees' homes or workplaces, ongoing monitoring process, and out-of-network care at no additional cost when in-network care is unavailable), with the largest number of commenters expressing support for the provision of out-of-network care at no additional cost when in-network care is unavailable. Other commenters recommended specific alternatives to these elements, such as a "60 minutes or 60 miles" or "15-20 minutes" standard.

Response: Based on comments, we have modified §156.230(a)(2) in this final rule to codify the standard that services must be available without unreasonable delay. With respect to the other specific suggestions offered by commenters, we are concerned that the proposed standards may not be compatible with existing State regulation and oversight in this area. We believe that the modification to final §156.230(a)(2) strikes the appropriate balance between assuring access for consumers and recognizing the historical flexibility and responsibility given to States in this area.

Comment: Several commenters recommended that the final rule strengthen access protections in medically underserved, rural, or professional shortage areas, and for vulnerable

populations, such as limited English proficient individuals or individuals with disabilities. With respect to medically underserved areas, some commenters suggested approaches that HHS could take, such as supporting higher payment rates in these areas. Others advocated for State flexibility to develop local solutions. One commenter requested that the final rule clarify that a QHP's network cannot be deemed inadequate in a professional shortage area.

Response: We did not accept comments recommending specific, national standards given that network adequacy is typically – and diversely – regulated by States. As described above, we amended §156.230(a)(2) in this final rule to clarify that the provider networks maintained by QHP issuers must offer access to all services without unreasonable delay. We believe that this modified standard enhances protections for all Exchange consumers, including vulnerable populations, while preserving flexibility for States to develop local solutions to ensure access. Furthermore, we believe that the standards for inclusion of essential community providers in QHP provider networks in proposed §156.235 will also help to strengthen access in medically-underserved areas and for vulnerable populations.

Comment: Many commenters recommended that the network adequacy provisions include specific provider types, such as pediatricians, tribal health care providers, mental health professionals, teaching hospitals, or women's health care providers.

Response: While QHP networks should provide access to a range of health care providers, we are concerned that mandating inclusion of a list of specified provider types would detract from the larger issue of broadly ensuring access to the full range of covered services (that is, essential health benefits). Accordingly, we have modified §156.230(a)(2) of this final rule to require QHP issuers to maintain networks that include sufficient numbers and types of providers, including providers that specialize in mental health and substance abuse, to ensure access to all

services. We specifically highlight mental health and substance abuse services because we recognize that the essential health benefits will create new demands for access to mental health and substance abuse services, and that such services have traditionally been difficult to access in low-income and medically underserved communities. By highlighting mental health and substance abuse providers in the network adequacy standard, we seek to encourage QHP issuers to provide sufficient access to a broad range of mental health and substance abuse services, particularly in low-income and underserved communities. In addition, we are clarifying in §155.1050 of this final rule that, because inclusion of essential community providers is related to network adequacy, a QHP issuer may not be prohibited from contracting with any essential community provider described in final §156.235(c). We urge States to consider local demographics, among other elements, when developing network adequacy standards and note that nothing in the final rule would preclude an Exchange from identifying specific provider types that are particularly essential in a State.

Comment: A few commenters recommended that the final rule direct QHP networks to maintain growth capacity, or the ability to accept additional enrollees or utilization.

Response: We believe that the higher standard in §156.230(a)(2) of this final rule helps address the commenters' concerns. Further, we believe that the reference to section 2702(c)(2) of the PHS Act, included in section 1311(c)(1) of the Affordable Care Act, implies Congressional intent to protect current enrollees from unreasonable delays in access to care if QHPs expand enrollment too quickly. Therefore, we are not prescribing a uniform growth capacity standard for all Exchanges in the final rule, though we note that an individual Exchange would be able to set such a standard.

Comment: A few commenters supported the language in the preamble to the proposed rule encouraging Exchanges and QHP issuers to consider broadly defining the providers that can furnish primary care services. However, other commenters raised concerns about this broader definition and noted that other programs, such as Medicare and Medicaid, identify a limited set of providers who may be considered primary care providers.

Response: We continue to encourage Exchanges to consider a broader definition of the types of providers who may furnish primary care services, because this should improve access to such services for consumers, particularly those in medically underserved or rural areas. We also recognize that the definition of a "primary care provider" should be consistent across health insurance programs to the extent possible, and we encourage Exchanges to be mindful of existing definitions and approaches in other health insurance programs when outlining corresponding standards for QHP issuers participating in the Exchange. All provider contracts executed by QHP issuers participating in the Exchange must be fully compliant with State scope of practice laws.

Comment: A few commenters requested that HHS provide technical assistance on the various network adequacy benchmarks that are available (for example, NAIC, Medicare Advantage, TRICARE, Medicaid managed care) as States develop Exchange standards.

Response: We continue to work with States on a variety of issues related to Exchange establishment and operations, and will consider providing more specific technical assistance on existing network adequacy standards in the future.

Comment: Several commenters recommended that additional items be included in QHP provider directories described under proposed§156.230(b), such as each provider's specialty, affiliation, licensure, or languages spoken. A few commenters requested that HHS establish that

the provider directory must be easily searchable for Indian Health Service/Tribal/Urban (I/T/U) providers. Finally, a few commenters recommended that provider directories include non-physician providers.

Response: Consistent with current industry practice, we expect QHP issuers' provider directories to include information on each provider's licensure or credentials, specialty, and contact information, which could include any institutional affiliation. The Exchange may establish additional data elements that QHP issuers must include, such as identifying Indian Health Service/Tribal/Urban (I/T/U) providers.

We note that while a provider directory could include appropriate non-physician providers, we afford Exchanges discretion regarding their inclusion in the provider directory. A provider directory that includes providers whose scope of practice is limited should generally identify the services that the provider is contracted to perform, for example, by displaying such providers only when consumers search for certain services (for example, primary care).

Comment: Multiple commenters recommended that the Exchange consolidate QHP provider directories as described in the preamble to the proposed rule. Conversely, some commenters recommended maximum flexibility for QHP issuers to submit provider information.

Response: We encourage, but do not direct, Exchanges to consolidate QHP provider directories to make it easier for consumers to locate the QHPs in which their providers participate. Exchanges may also want to establish links to the provider directory on a QHP issuer's Web site.

Comment: Several commenters requested that HHS clarify how frequently QHP issuers must update provider directories under proposed §156.230(b). Recommendations offered by commenters ranged from in real time to annually. A few commenters raised concerns about the

proposed standard that directories identify providers who are not accepting new patients, noting that this could result in continuous updates.

Response: We afford each Exchange with discretion to provide guidance to QHP issuers with respect to the updating of provider directories, including how frequently issuers must identify providers who are no longer accepting new patients. We urge Exchanges to consider the appropriate balance between supporting consumer choice and the burden on QHP issuers associated with this standard (which we should be lower for electronic directories than for hard copy directories). Further, in establishing such standards, we expect Exchanges to consider the information needs of current versus potential enrollees.

Comment: A few commenters recommended that HHS establish that provider directories developed in accordance with proposed §156.230(b) must offer meaningful access to individuals with limited English proficiency and/or disabilities, for example by making directories available by phone.

Response: We note that, because they are made available to enrollees, provider directories must meet the standards for applications, forms, and notices established in §155.230 of this final rule, which include accommodations for individuals with limited English proficiency and/or disabilities.

Comment: A few commenters suggested that QHP issuers be directed to notify enrollees if their particular provider drops out of the network.

Response: Although a provider's contracting status has significant implications for patients - especially those who regularly see a particular provider for treatment of a chronic or complex condition - we do not set a uniform standard for notification of individual patients if

their providers drop out of the QHP's network. Such a uniform standard on QHPs might not be consistent with practices in the non-Exchange market, and would raise QHP administrative costs.

Comment: HHS received comments that section 408 of the Indian Health Care Improvement Act (IHCIA), should be interpreted to obligate QHPs to include health programs operated by the IHS, Tribes, Tribal organizations, and Urban Indian organizations as providers in their networks. Several commenters also recommended that HHS clarify the applicability of section 206 of the ICHIA to QHPs.

Response: The primary purpose of section 408 of IHCIA is to deem Indian health providers as eligible to receive payment from Federal Health Care Programs for health care services provided to Indians if certain standards are met. Eligibility to receive payment under section 408 of IHCIA does not depend on in-network status with a QHP. Section 206 of IHCIA provides that all Indian providers have the right to recover from third party payers, including QHPs, up to the reasonable charges billed for providing health services, or, if higher, the highest amount an insurer would pay to other providers to the extent that the patient or another provider would be eligible for such recoveries. We believe that section 206 will foster network participation because it benefits QHPs to contract with Indian health providers to establish the payment terms to which the parties agree. Accordingly, we are not modifying the regulation text to reflect this comment.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.230 of the proposed rule with the following modification: in new paragraph (a)(2), we modified the standard previously proposed in §155.1050 to clarify that a QHP issuer must maintain a provider network that is sufficient in number and types of providers to assure that all services will be accessible without unreasonable

delay. We also specifically include providers that specialize in mental health and substance abuse, because mental health and substance abuse services are essential health benefits and because mental health parity applies to QHPs.

f. Essential community providers (§156.235)

In §156.235, we proposed that a health plan's network must include a sufficient number of essential community providers who provide care to predominantly low-income and medically-underserved populations to be certified as a QHP. We solicited comment on how to define a sufficient number of essential community providers. We also defined the types of providers included in the definition of essential community providers consistent with the Affordable Care Act, which specifically identifies all health care providers defined in section 340B(a)(4) of the PHS Act and providers described in section 1927(c)(1)(D)(i)(IV) of the Act. We also solicited comment on the extent to which the definition should include other similar types of providers that serve predominantly low-income, medically-underserved populations and furnish the same services as the providers referenced in section 340B(a)(4) of the PHS Act.

In the preamble to this section, we acknowledged that two provisions of the Affordable Care Act regarding payment of essential community providers and payment of Federally Qualified Health Centers (FQHCs) may conflict and invited comment on this issue. We also invited comment on specific payment and contracting issues related to Indian health providers. Finally, we requested comment on other special accommodations that should be made when contracting with Indian health providers, such as the use of a standardized Indian health provider contract addendum.

Comment: HHS received many comments seeking clarity on the proposed standard in §156.235(a) that QHPs include in their provide networks a "sufficient" number of essential

community providers. Many commenters recommended that QHP issuers include in their provider networks all essential community providers in the area; contract with any willing essential community provider; or contract with certain types of providers, such as family planning providers. Some commenters suggested HHS define sufficiency based on specific ratios of enrollees to providers, maximum travel times, or the Need for Assistance worksheet used by the Health Resources and Services Administration[12]. One commenter suggested that HHS base the sufficiency standard in part on the Health Professions Shortage Areas, Medically Underserved Areas and Medically Underserved Populations designated by the Health Resources and Services Administration.

In contrast, other commenters supported the proposed rule and urged HHS to maintain a broad definition of "sufficient" that allows Exchanges to establish standards appropriate for their States. A number of commenters urged HHS to strike a balance between having QHP issuers provide enrollees with adequate access to care from essential community providers and allowing QHP issuers to employ innovative network designs that improve quality and contain costs.

Response: Based on comments received, we believe that additional clarification of the "sufficiency" standard is necessary. Accordingly, we have modified final §156.235(a) to direct that each QHP's network have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards. We believe that this approach more clearly articulates our expectations with respect to sufficiency than the standard included in the proposed rule with respect to essential community providers while continuing to balance the accessibility of essential community providers with network flexibility for issuers. We

[12] Available at: http://www.hrsa.gov/grants/apply/assistance/NAP/forms/9needforassistance.pdf.

emphasize that Exchanges have the discretion to set higher, more stringent standards with respect to essential community provider participation, including a standard that QHP issuers offer a contract to any willing essential community provider. HHS intends to monitor the effectiveness of this provision in ensuring access to essential community providers, and it may be subject to further modification.

Comment: HHS received several comments suggesting that QHP issuers be exempt from the standard in proposed §156.235(a) to include essential community providers in their provider networks if the Exchange's service area does not include low-income or medically-underserved populations.

Response: Section 1311(c)(1)(C) of the Affordable care Act directs all QHP issuers to include essential community providers in their provider networks; therefore, we have not amended the regulation to provide the exemption suggested by the commenter. Further, we note that the statute and final rule acknowledge that essential community providers may not be available throughout a QHP's service area. We believe that the inclusion of "where available" in both places creates flexibility for QHP issuers to contract with essential community providers in a manner that reflects the relative availability of these providers and the needs of local communities.

Comment: A number of commenters urged us to address the services that a QHP issuer should cover when provided by an essential community provider in its provider network, as described in proposed §156.235(a)(1). Some commenters suggested that QHP issuers be directed to cover all services furnished by the essential community provider. Some commenters expressed concern that QHP issuers might contract with essential community providers for a few services,

thus fulfilling the essential community provider "sufficiency" standard but prohibiting access to the full breadth of services through such providers.

Response: While we believe the statutory directive to include essential community providers in QHP provider networks must translate to meaningful access to care for low-income and medically underserved populations, section 1311(c)(1)(C) of the Affordable Care Act provides that nothing in the standard to include essential community providers obligates a QHP to cover any specific medical procedure. We generally anticipate and expect QHP issuers will contract with essential community providers for all services furnished by the provider that are otherwise covered by the QHP.

Comment: Several commenters supported an exemption from the standards in this section for staff-model health plans or integrated delivery system-based health plans, though one commenter urged HHS to make such an exemption contingent upon the organization demonstrating that its provider network still provides meaningful access to all forms of care to potential enrollees in the service area. One commenter suggested that HHS establish a provision similar to Medicaid's "freedom of choice" provision in 42 U.S.C. 1396(a)(23) in order to allow enrollees in staff-model QHPs to receive covered services from other providers if needed at no additional cost to the enrollee; the commenter specifically cited concerns that a religiously-sponsored integrated delivery health plan may not offer a full range of reproductive health services. Conversely, several commenters opposed any exemption for staff-model or integrated delivery system plans.

Response: Based on comments, we are persuaded that the obligation to contact with essential community providers should address the unique contracting structure of staff-model health plans and integrated delivery system-based health plans that provide a majority of services

"in-house." We are concerned that establishing a standard for such plans to contract with essential community providers would result in these plans having to alter their business models, which may obviate the benefits of integration. In the proposed rule, we noted that we were weighing whether to provide consideration for plans that solely provide services "in-house". In light of comments, however, we recognize that staff model and highly integrated delivery system plans do not provide services solely "in house"; rather, as a practical matter, they must provide some level of out-of-network services (for example, emergency services) and often must contract with Centers of Excellence or certain specialists to provide patients with access to highly specialized services. As a result, we have added under final §156.235(b) a provision directing Exchanges to offer an alternate standard for plans with a majority of services furnished by "in-house" providers. Under the alternate standard, health insurance issuers that provide a majority of covered professional services through employed physicians or through a single contracted medical group may demonstrate their ability to provide an equivalent level of service accessibility for low-income and medically underserved individuals. We note that this alternate standard does not permit an Exchange to grant any QHP issuer a wholesale exception to standards related to essential community providers.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters urged HHS to clarify the term "generally applicable payment rates" and ensure that essential community providers are reimbursed at a reasonable level by establishing minimum reimbursement standards for all essential community providers. Suggestions for such a benchmark included the Medicaid prospective payment system (PPS) rate under 42 USC 1396a(bb), Medicare rates, or a reimbursement rate at least equal to the issuer's negotiated rate with a similarly situated non-essential community provider. Commenters also recommended that

QHPs offer "generally applicable payment rates" by service line to ensure that plans do not mask low rates for particular services by providing higher rates for less-utilized service, or otherwise discriminate against essential community providers in contract negotiations.

Response: QHP issuers should not discriminate against essential community providers through contract negotiations, or otherwise attempt to circumvent the obligation to include such providers in-network by offering unfavorable rates. In this final rule, we are not specifically establishing that a generally applicable payment rate be based on a particular benchmark or be calculated using a particular method (for example, by service line), but clarify that "generally applicable payment rate" means, at a minimum, the rate offered to similarly situated providers who are not essential community providers as defined in this section.

Comment: In response to the discussion in the preamble to the proposed rule, many commenters offered feedback on the appropriate payment rates for Federally-qualified health centers, or FQHCs. Several commenters supported payment of Medicaid PPS rates to all FQHCs some commenters advocated that Exchange provide wrap-around payments to FQHCs, as is currently the practice in State Medicaid programs. Other commenters supported payment of the issuer's generally applicable payment rates, while other commenters recommended allowing payment of mutually agreed upon rates. A few commenters offered unique suggestions not explicitly contemplated in the proposed rule, such as negotiating based on Medicare rates or permitting States to establish payment rates for essential community providers.

Response: The Affordable Care Act, at section 1302(g), establishes payment of FQHCs at the applicable Medicaid PPS rate. However, the Affordable Care Act also supports, at section 1311(c)(2), payment of essential community providers, including FQHCs, at the QHP issuer's generally applicable payment rate. We are amending the regulation text in final §156.235(e) to

codify both sections 1302(g) and 1311(c)(2) of the Affordable Care Act. We interpret these two provisions to mean that a QHP issuer must pay an FQHC the relevant Medicaid PPS rate, or may pay a mutually agreed upon rate to the FQHC, provided that such rate is at least equal to the QHP issuer's generally applicable payment rate.

Comment: Several commenters suggested that, rather than direct QHP issuers to contract with essential community providers under proposed §156.235(a), Exchanges should provide incentives for QHP issuers to contract with essential community providers.

Response: Including essential community providers in QHP provider networks is a minimum certification standard specifically established by Section 1311(c)(1)(B) of the Affordable Care Act. This does not preclude Exchanges from offering incentives to QHP issuers (such as priority placement on the Exchange Internet Web site) to contract with more essential community providers than the Federal minimum standard.

Comment: In response to the list of essential community providers in proposed §156.235(b), many commenters recommended inclusion of specific provider types, including but not limited to rural health clinics, community mental health centers, family planning clinics, Ryan White Care Act providers, pediatricians and children's hospitals, tribal health care providers, providers that serve limited English proficient populations, school-based clinics, or the entirety of a health system that includes a 340(B) or disproportionate share hospital. Some commenters also expressed concern about the potential for exclusion of or discrimination against specific types of essential community providers, such as those that are academic medical centers, by issuers, States or Exchanges. Conversely, a few commenters recommended that each State define essential community providers.

Response: We acknowledge that a wide variety of health care providers and institutions serve low-income and medically underserved individuals, and we note that the definition of essential community providers contained in the proposed rule encompasses a broad range of providers that serve low income and underserved communities, including FQHCs, disproportionate share hospitals, Ryan White Care Act Title II and III grantees, and urban Indian organizations. We clarify that the list of essential community providers provided in paragraphs (c)(1) and (c)(2) are not an exhaustive list and are not meant to exclude QHP issuers from contracting with other providers that serve predominantly low-income, medically underserved individuals.

In §156.235(c) of the final rule, we are finalizing the proposed rule definition, with a slight modification. Based upon comments regarding the potential for exclusion of or discrimination against essential community providers and consistent with the intent explicit in section 1311(c)(1)(C) of the Affordable Care Act that access to essential community providers be maximized in QHPs, we clarify that any provider that meets the criteria for an essential community provider in §156.235(c), or met the criteria on the publication date of this regulation unless the provider lost its status under §156.235(c)(1) or (c)(2) thereafter as a result of violating Federal law, must be considered an essential community provider. We intend to monitor this policy and revisit as necessary.

We note that the definition in the final rule, taken from the section 1311(c)(1)(C) of the Affordable Care Act, provides a test to determine whether a provider is an essential community provider and a non-exhaustive list of examples. An Exchange may apply the test contained in the definition (providers that serve predominantly low-income, medically underserved individuals) to a particular service area to identify additional essential community providers. Finally, we note

that each QHP provider network must be sufficient in number and types of providers to assure that all services, including mental health and substance abuse services, will be accessible without unreasonable delay.

Comment: A few commenters recommended that HHS develop a standard Indian Addendum for contracting with tribal health care providers.

Response: We recognize that furnishing QHP issuers with a standard Indian Addendum to a provider contract may make it easier for QHP issuers to contract with Indian providers. We note that QHP issuers may not be aware of the various Federal authorities that govern contracting with Indian health providers, and such an Addendum may lower the perceived barrier of contracting with Indian providers. We plan to develop a template for contracting between QHP issuers and tribal health care providers. While we do not uniformly mandate that QHP issuers use the template, we believe that QHP issuers will find it in their interest to adopt such a template when contracting with Indian providers. We also note that Exchanges may elect to direct QHP issuers to use the Indian Addendum when contracting with Indian providers.

Comment: One commenter recommended that all entities designated as essential community providers qualify for special drug pricing under section 340B(a)(4) of the Public Health Service Act. Conversely, another commenter requested that the final rule clarify that QHP issuers are not obligated to contract with all 340(B) pharmacies. One commenter suggested that HHS work with States and Exchange governing boards to ensure that providers have a clear understanding of how key 340(B) principles apply in the Exchange context in order to avoid confusion and violation of 340(B) anti-diversion rules.

Response: This rule concerns the establishment and operation of Exchanges and the certification standards for QHPs; nothing in this final rule changes or affects the operation of

section 340(B) of the Public Health Service Act. As a result, requests to interpret section 340B of the Public Health Service Act are outside the scope of this final rule.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.235 of the proposed rule, with the following modifications: in paragraph (a)(1) we modified QHP issuer's contracting responsibilities with respect to essential community providers to reflect a reasonable access standard and a broad range of providers standard. In new paragraph (a)(2) we added an alternate standard for QHP issuers that provide a majority of professional services with "in-house" providers. In paragraph (c), we clarified the definition of an essential community provider. We also added new paragraphs (d) and (e) to interpret and implement Affordable Care Act section 1311(c)(2) (regarding payment rates to essential community providers) and section 1302(g) (regarding payment of FQHCs); in doing so we indicate that QHP issuers and FQHCs may negotiate rates and mutually agree on a payment rate other than the Medicaid PPS rate.

g. Treatment of direct primary care medical home (§156.245)

In §156.245, we proposed to permit QHP issuers to provide coverage through a direct primary care medical home (PCMH) that meets the standards established by HHS, provided that the QHP meets all standards otherwise applicable. We requested comment on what standards HHS should establish under this section.

Comment: Multiple commenters recommended that direct PCMHs described in proposed §156.245 be accredited, or comply with existing industry standards such as the Joint Principles of the Patient-Centered Medical Home[13] developed by the Patient Centered Primary Care Collaborative. Other commenters expressed general support for PCMHs or provided data on the effectiveness of the PCMH model.

[13] Available at: http://www.pcpcc.net/content/joint-principles-patient-centered-medical-home.

Response: We believe that Exchanges offer an opportunity to advance innovative models of delivery that can improve the care experience for patients and providers. Consistent with this overall goal, we have structured the direct PCMH provision to encourage, rather than limit, innovative care models. While we recognize the importance of accreditation and quality assurance, we are not establishing that direct PCMHs be accredited in order to participate in QHP networks. We encourage QHP issuers to consider the accreditation, licensure, or performance of all network providers.

Comment: Several commenters suggested that the definition of direct PCMHs in proposed §156.245 be expanded to include accountable care organizations or specialists who serve as a patient's "health home."

Response: While non-primary care clinicians can play a significant role in care coordination, particularly for patients with multiple or complex conditions, the statute specifically provides for inclusion of primary care medical homes. We do not interpret that phrase as including providers of non-primary care services, such as specialists. However, we note that nothing in this section prohibits or limits a QHP issuer's ability to pursue other innovative care models or contracting structures, such as increasing payments to specialists who coordinate an individual's care, or contracting with accountable care organizations.

Comment: A few commenters requested that HHS clarify what coordination is contemplated between a QHP and a contracted direct PCMH under proposed §156.245.

Response: QHP issuers that choose to contact with direct PCMHs for primary care services will need to consider how to promote a seamless consumer experience. For example, the QHP issuer should ensure that enrollees understand how to use the direct PCMH model, identify

which services will be provided by the direct PCMH and which will not, and have clear information on how to access specialists and other non-primary care providers.

Comment: Several commenters generally recommended that HHS encourage QHP issuers to contract with direct PCMHs, direct issuers to contact with a specific number of direct PCMHs, establish that a certain percentage of network providers must be affiliated with direct PCMHs, or direct QHP issuers to report on the number of in-network direct PCMHs.

Response: While we believe that an Exchange could create incentives for QHP issuers to contract with direct PCMHs, such incentives are more appropriately considered within the context of local provider market conditions, including the relative availability of direct PCMHs. As a result, we are not directing Exchanges to create incentives for contracting with direct PCMHs. We encourage Exchanges to promote, and QHP issuers to explore, innovative models of delivery along the care spectrum.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.245 of the proposed rule without modification.

h. Health plan applications and notices (§156.250)

In §156.250, we proposed basic standards for the format of applications and notices provided by the QHP issuer to the enrollee, specifically that QHP issuers must adhere to the standards established for notices in §155.230.

We received a number of comments on this section. Because §156.250 cross-references to §155.230, we have responded to all comments on applications and notices in §155.230. Accordingly, we are finalizing §156.250 as proposed.

i. Rating variation (§156.255)

Consistent with the rating rules established in the Affordable Care Act, we proposed §156.255 to codify the statutory provision that allows QHP issuers to vary premiums by the rating areas established under section 2701(a)(2) of the PHS Act. We further proposed that each QHP issuer offer a QHP at 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. We also proposed that a QHP issuer cover all the following groups using some combination of the following categories: (1) individuals; (2) two-adult families; (3) one-adult families with a child or children; and (4) all other families. We sought comment on how we might structure family rating categories while adhering to section 2701(a)(4) of the PHS Act, which establishes that any family rating using age or tobacco rating may only apply those rates to the portion of the premium that is attributable to each family member.

Additionally, we requested comment on how to apply four family categories when performing risk adjustment. We also invited comment on alternatives to the four categories for defining family composition, and how to balance potential consumer confusion associated with more categories while maintaining plan offerings and rating structures that are similar to those that are currently available in the health insurance market. Finally, we noted that we were also considering whether to direct QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates, and sought comment on the potential considerations of this approach.

Comment: A few commenters asked why the proposed rule did not address section 1312(c) of the Affordable Care Act related to a single risk pool.

Response: The proposed rule and this final rule only address standards that are unique to Exchanges, QHP issuers and QHPs. The single risk pool provision applies to health insurance

issuers in the individual and small group market and to enrollees who do not enroll in health plans through the Exchange. Therefore, it is outside the scope of this final rule. We anticipate future rulemaking on other Affordable Care Act provisions that apply to insurance markets generally.

Comment: One commenter suggested that the final rule establish a process whereby a State demonstrates that existing State laws related to rating outside of the Exchange will not undermine the Exchange.

Response: We are continuing to evaluate the relationship and interaction of State rating laws, the market reform provisions in section 2701 of the PHSA, and the provisions to implement the Exchange standards. We may issue further guidance in the future.

Comment: In response to the proposed §156.255(a) on rating areas, one commenter suggested that we codify the standard that rating areas must be applied consistently inside and outside of the Exchange, which we discussed in preamble of the proposed rule (76 FR 41901). A few commenters requested that HHS establish a standard set of criteria for rating area boundaries that reflect actual differences in health costs within a State.

Response: Section 2701(a)(2) of the PHS Act directs States to establish rating areas, which will be reviewed by the Secretary of HHS. Section 1301(a)(4) of the Affordable Care Act directly references the rating areas outlined in section 2701(a)(2) of the PHS Act, which ensures that the rating areas are applied consistently both inside and outside the Exchange. The requested provision is outside the scope of this final rule; we anticipate future rulemaking on other Affordable Care Act provisions that apply to insurance markets generally.

Comment: Several commenters requested that HHS more clearly define what "same plans" would need to be offered at the same premium rate for proposed §156.255(b). The

commenters raised concerns that issuers would offer two plans with very minor differences and then charge a different premium for what is essentially the same plan, which could result in adverse selection against the Exchange.

Response: We believe that, generally, this provision means that health plans that are substantially the same as a QHP should charge the same premium and encourage States to use this standard when evaluating compliance with this provision. HHS may further clarify this standard in future rulemaking or guidance.

Comment: Several commenters voiced support for proposed §156.255(b), while others had questions regarding whether user fees charged for enrollment would undermine the same premium provision. Some commenters suggested that HHS direct Exchanges to apply user fees to QHPs offered outside of the Exchange in order to ensure pricing parity.

Response: We clarify that States have substantial flexibility in establishing a funding mechanism for an Exchange to meet the self-sustaining provision of section 1311(d)(5) of the Affordable Care Act, implemented in this final rule at §155.160. As noted in the statute and the regulation text, user fees on QHPs are one mechanism to achieve this status. Such fees may be set based on a broad or narrow set of issuers, on enrollment volume, including enrollment that is not through the Exchange, or be set without regard to enrollment.

Comment: Several commenters suggested that we direct QHP issuers to offer QHPs outside of the Exchange.

Response: Nothing in Federal law prohibits a QHP issuer from offering the QHP for sale directly to an individual or through an agent/broker in addition to through the Exchange. We note that a State law may address this issue. Further, enrollees in such a plan would not qualify for advanced payments of premium tax credits, among other Exchange benefits.

Comment: In response to proposed §156.255(c), several commenters raised issues regarding rating rules that were discussed in the proposed rule, including the incorporation of the tobacco rating factor described in section 2701(a)(1)(A)(iv) of the PHS Act (76 FR 41901). Other commenters made suggestions about the application of a rating structure to a tax household.

Response: In the final rule, we have removed proposed §156.255(c), which addresses rating categories. We anticipate that implementation of section 2701(a)(1)(A) of the PHS Act will establish standards that apply to health insurance issuers in the individual and small group market, including QHP issuers.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.255 of the proposed rule, with the exception of removing paragraph (c).

j. Enrollment periods for qualified individuals (§156.260)

In §156.260, we proposed that QHP issuers must accept and enroll qualified individuals during the initial open enrollment period, during the annual open enrollment period thereafter, and during special enrollment periods, as applicable. We further proposed that QHP issuers adhere to the effective dates of coverage established in §155.410 for all enrollment periods in the Exchange, and provide enrollees with notice of effective dates of coverage.

Comment: HHS received many comments about enrollment periods in accordance with §155.410 and §155.420, which are summarized and addressed in those sections of the final rule. One commenter remarked specifically on proposed §156.260 and requested that HHS clarify whether a QHP could refuse enrollment to an applicant previously proven to have committed fraud.

Response: A QHP issuer may not refuse enrollment to a new applicant who has previously proven to have committed fraud. We note that section 2703(b) of the PHS Act, with which QHP issuers must comply, includes an exception to the guaranteed renewability standard in certain instances of fraud, but includes no parallel exception for new coverage. We further note that §156.270(a) permits QHP issuers to rescind coverage under certain circumstances.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.260 of the proposed rule, with a minor technical modification and no substantive changes.

k. Enrollment process for qualified individuals (§156.265)

In §156.265, we proposed that QHP issuers adhere to the Exchange's process for enrollment in QHPs, which includes standards for the collection and transmission of enrollment information. Additionally, we proposed that QHP issuers use the application adopted in accordance with §155.405 when accepting applications from individuals seeking to enroll in a QHP through the Exchange enrollment process. After collecting the uniform enrollment information from an applicant, we proposed that the QHP issuer send the information to the Exchange, in accordance with the standards established in §155.260 and, as applicable, §155.270.

Consistent with the standards established in accordance with §155.260 and in §155.270, we proposed that QHP issuers receive enrollment information electronically from the Exchange. We sought comment on the frequency with which plans should receive electronic enrollment information. We also proposed that QHP issuers abide by the premium payment process established by the Exchange and described in §155.240.

We further proposed that QHP issuers provide enrollees in the Exchange with an enrollment package, and the summary of benefits and coverage document. We solicited comment on what should be included in an enrollment package. Finally, we proposed that QHP issuers reconcile enrollment files with the Exchange no less than once a month, and that QHP issuers acknowledge the receipt of enrollment information in accordance with Exchange standards established in §155.400.

Comment: Some commenters recommended that proposed §156.265(b) prohibit agents, brokers and web-based entities from performing eligibility determinations.

Response: An agent, broker, or web-based entity cannot perform eligibility determinations as part of enrollment through the Exchange. We note that section (b)(2)(A) of 36B of the Internal Revenue Code as amended by the Affordable Care Act establishes that an individual must enroll "through the Exchange" in order to access advance payments of the premium tax credit and cost-sharing reductions. However, in §155.220(c)(1), we specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker only if the agent or broker ensures that the individual receives an eligibility determination through the Exchange Web site.

Comment: In response to the provisions described in proposed §156.265(b), several commenters suggested that an individual have an eligibility determination before enrolling in a QHP. Other commenters expressed concern regarding the privacy of individuals' information when a QHP issuer facilitates the enrollment of an individual through the Exchange as described in proposed §156.265(b), particularly when the individual seeks an eligibility determination. One commenter suggested that the QHP issuer refer individuals to the Exchange to carry out activities related to eligibility and enrollment.

Response: An individual must receive an eligibility determination from the Exchange before enrolling in a QHP through the Exchange. Accordingly, we have added new paragraph §156.265(b)(1) to clarify that the QHP issuer may only enroll a qualified individual after the Exchange has notified the QHP issuer that the individual has been determined eligible consistent with the standards identified in part 155 subpart D, and on the basis of enrollment information sent from the Exchange to the QHP issuer. In addition, in §156.265(b)(2), we specify that QHP issuers must direct the individual to file an application with the Exchange or ensure the applicant receives an eligibility determination for coverage through the Exchange through the Exchange internet Web site. These provisions ensure that the applicant's information is collected only by the Exchange and thus firewalled from issuers and agents and brokers and accordingly protected. We do not provide regulatory standards for enrollment in a QHP that is not enrollment through the Exchange and defer to issuers as to their business practices for that. We reiterate that the assistance and protections described in part 155 apply to Exchange enrollment.

Protecting the personal health and other information provided by potential enrollees during the eligibility and enrollment process is critical. Further, we note that when the QHP issuer conducts relevant enrollment functions on its own behalf, that appears to be an activity covered by the HIPAA privacy and security rules in part 164.

Comment: HHS received a few comments in response to proposed §156.265(d), which obligates issuers to follow the premium payment process established in §155.240. One issuer recommended that payment directly to the QHP serve as the last resort for enrollees, another commenter requested that enrollees retain this option in the final rule. One commenter suggested that the enrollee pay only one entity (that is, the Exchange or the QHP issuer) for the entire

benefit year. Finally, one commenter suggested that the Exchange be directed to aggregate premiums to avoid unpredictable administrative costs for issuers.

Response: As this option is statutorily established under section 1312(b) of the Affordable Care Act, consumers must have the option to remit premium payments directly to QHP issuers. Therefore, we are maintaining the language in §155.240(a), which directs an Exchange to allow enrollees to pay premiums directly to QHP issuers. For a full discussion of issues related to premium payment, please refer to the responses to comment in §155.240.

Comment: Many commenters offered suggestions related to the enrollment package described under proposed §156.265(e). Many commenters recommended that HHS establish meaningful access standards; standards suggested by commenters included language written at the 6$^{th}$ grade level, in-language "taglines" in fifteen languages directing enrollees to oral translation services, or existing HHS Limited English Proficiency guidance. Other commenters recommended that the package include information about how to file a complaint. Some commenters suggested that HHS direct issuers to follow existing State and Federal law governing the contents of enrollment packages.

Response: The enrollment information package is subject to the accessibility and readability standards established in §156.250, which cross-references the access standards set forth in section §155.230(b); therefore, we have not amended the regulation text in this section because it would be duplicative. States have the flexibility to establish that the enrollment package include information on grievance and appeal rights, but we note that this information is already described in the summary of benefits and coverage as specified in guidance published by the Departments of HHS, Labor, and the Treasury under PHS Act section 2715, which an

enrollee would receive at essentially the same time. We also note that issuers must continue to follow existing law regarding the content of the enrollment package.

Comment: One commenter suggested that QHP issuers be able to attach the individual's choice of QHP to the individual's application to determine eligibility when that application originates with the QHP issuer.

Response: HHS will consider comments recommending that an individual's QHP selection be included in an application that is initiated with the QHP issuer as we develop guidance.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.265 of the proposed rule, with the following modifications: we have rewritten paragraph (b) to describe more clearly the process to enroll an applicant through the Exchange when the applicant approaches the QHP issuer directly. We modified paragraph (e) to state that the enrollment information package must comply with accessibility and readability standards in §155.230(b). We eliminated paragraph (f) referencing the summary of benefits and coverage document. Because of the elimination of the paragraph on summary of benefits and coverage, the remaining provisions have redesignated numbers.

l. Termination of coverage for qualified individuals (§156.270)

In §156.270, we proposed standards for QHP issuers regarding the termination of coverage of individuals enrolled in QHPs through the Exchange, and proposed that a QHP issuer may terminate coverage for non-payment of premium, fraud and abuse, and relocation outside of the service area, among other situations permitted by the Exchange. Additionally, we proposed that QHP issuers provide a notice of termination of coverage to the enrollee and the Exchange,

consistent with the standards for effective dates in §155.430. We solicited comment on the information that should be included in the termination notice.

We also proposed standards for QHP issuers regarding the application of the grace period for non-payment of premiums by individuals receiving advance payments of the premium tax credit. Specifically, we proposed that a QHP issuer must provide a grace period of at least three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one month's premium. During the grace period, we clarified that the QHP issuer must pay all appropriate claims, apply any payment received to the first billing cycle in which payment was delinquent, and continue to collect the advance payments of the premium tax credit on behalf of the enrollee from the department of the Treasury.

We also proposed to direct QHP issuers to provide a notice to enrollees who are delinquent on premium payments and sought comment on the potential elements of such a notice. Additionally, we proposed that QHP issuers maintain records of terminations of coverage in accordance with Exchange standards as established in §155.430. Finally, we proposed that QHP issuers abide by the effective dates for termination of coverage as described in §155.430.

Comment: Many commenters were concerned that the notices described in proposed §156.270(b) and (e) should meet meaningful access standards and are accessible for LEP individuals and for individuals with disabilities.

Response: QHP notices must meet standards for LEP individuals and for individuals with disabilities. Section 156.250 of the final rule states that all notices from a QHP issuer must meet the standards outlined in §155.230(b).

Comment: Some commenters were concerned that a QHP issuer could terminate coverage under this section without sufficient notice. Other comments urged HHS to track reasons for termination of coverage for oversight purposes. Finally, a few commenters asked us to clarify how QHP issuers and the Exchange would share information about termination of coverage.

Response: In response to comments, we have added paragraph (b)(1) to the final rule to state that QHP issuers must notify enrollees at least 30 days prior to terminating coverage, and further that the notice must include a reason for termination. We also added 156.270(b)(2) to the final rule to state that the QHP issuer must notify the Exchange of the termination effective date and reason for termination.

Comment: A significant number of commenters voiced concerns that the proposed policy in §156.270(d) that directed QHP issuers to pay all appropriate claims during the 3-month grace period would exacerbate adverse selection and increase premiums across enrollees. Several commenters representing the insurance industry specifically noted that under the proposed policy, rates would be built with an assumption that some portion of enrollees would pay 9 months of premium for 12 months of full coverage.

Several alternatives were suggested, such as allowing QHP issuers to pend claims after the first 30 days of non-payment, which would allow the issuer to put a hold on claims until the end of the grace period, at which point such claims would be paid if the premiums were paid, or denied if the premiums were not paid. Another commenter suggested allowing QHP issuers to deny coverage for certain categories of services, such as elective, non-emergency procedures, additions of new household members, or new prescription drugs. Other commenters suggested that each Exchange be allowed to determine the payment policy, and some recommended that

Exchanges be responsible for helping to pay outstanding premiums or for seeking payment of outstanding premiums from an individual.

Response: We did not accept the recommendation that each Exchange set its own standard. Advance payments of the premium tax credit are directly tied to the grace period. Thus the grace period's parameters will have an impact on potential Federal tax liability of consumers and on Federal administration of the advance payments of the premium tax credit. As a result, it is critical that the Federal government establish a uniform grace period policy to balance the potential impacts on the consumer's tax liability, coverage liability for issuers and providers, and appropriate administration of advance payments of the premium tax credit.

However, we are persuaded that the proposed standards should be adjusted in this final rule to decrease the opportunities for risk manipulation, adverse selection, and premium increases. In §156.270(d)(1) and (d)(2) of the final rule, we now direct QHP issuers to pay all appropriate claims for services provided during the first month of the grace period. We believe that the first month of non-payment is the month in which an enrollee is the most likely to resume timely payments, and thus is the time period in which it is most important to ensure seamless coverage. As such, issuers should adjudicate claims as they would for any enrollee that pays his or her premium in full. However, we acknowledge that as the amount owed by an enrollee increases during the 3-month grace period, the risk of non-payment increases as well. To decrease the financial risk to issuers, and to individuals as described below, the final rule now permits QHP issuers to pend claims in the second and third months. We note that QHP issuers may still decide to pay claims for services rendered during that time period in accordance with company policy or State laws, but the option to pend claims exists. If the individual settles all outstanding premium payments by the end of the grace period, then the pended claims would be

paid as appropriate. If not, the claims for the second and third months could be denied. The grace period under this final rule represents an extended time for enrollees to catch up on premium payments before coverage is terminated. Several considerations informed this amended approach.

First, the statutory 3-month grace period is substantially longer than many current grace periods and only applies to recipients of advance payments of the premium tax credit, assuming they have paid at least one monthly premium. In light of this fact, a grace period policy that is significantly different from the rest of the market could produce markedly different premiums between the Exchange and non-Exchange markets. The final rule approach helps mitigate these concerns by aligning the grace period claims payment standards more closely with current industry practices.

Second, in accordance with section 36B of the Code, individuals may incur a tax liability for any advance payments of the premium tax credit that are paid on their behalf for a month that such individual did not pay his or her portion of the premium. Under the policy in the proposed rule, an individual would potentially be liable for three months of advance payments of the premium tax credit, which could be substantial in some instances. Given the potential for a large tax liability on the part of enrollees receiving advance premium tax credits that fail to pay their residual premiums to QHP issuers, we believe that a retroactive termination date is appropriate to mitigate excessive individual financial exposure. Under the final rule policy, an individual's financial exposure would be limited to the first month's advance payment of the premium tax credit if the individual did not pay his or her portion of the premium for that month. We have provided several examples below to illustrate how the new grace period policy would work:

**Grace Period Examples:**

Assumptions for a monthly premium:

- Premium: **$500**
- Advance premium tax credit share of premium: **$450**
- Enrollee share of premium: **$50**
- First month of grace period: **March**
- Individual pays enrollee share of premium for January and February coverage.

Example #1: Individual misses $50 payment that is due February 28 for March coverage. Individual realizes mistake and pays $100 on March 31st for March and April coverage, satisfying all obligations for premium payments through the end of March.

- Issuer adjudicates claims for March consistent with normal practices (that is, for non-grace periods)
- Individual will have full coverage for March and April
- Individual has paid full premium for March and April as is eligible for premium tax credit for March and April.

Example #2: Individual misses $50 payment that is due February 28 for March coverage and misses $50 payment that is due March 31st for April coverage. Individual Pays $150 on April 30 for March, April and May coverage.

- Issuer adjudicates claims for March
- Coverage continues for April and May (2nd and 3rd months of the grace period), but:
  - Providers are notified of the potential for a denied claim
  - Issuer pends claims for services performed in April and May until individual pays outstanding premiums.

- Individual has paid full premium for March, April and May as is eligible for premium tax credit for March, April and May.

Example #3: Same facts as Example #2 except that individual does not pay enrollee's share of premium for March, April or May.

- Coverage terminated retroactively to March 31
- Issuer can deny claims for services rendered during April and May. Providers could then seek payment directly from the individual for any services provided during that time.
- Individual may have additional tax liability attributable to the $450 for the advance payment of the premium tax credit paid on his or her behalf for March's coverage. The exact amount of additional tax liability would be determined in accordance with the rules for tax credit reconciliation under section 36B of the Code.

Comment: Several commenters supported the proposed standards in §156.270(d) that QHP issuers pay all appropriate claims during the 3-month grace period for enrollees receiving advance payments of the premium tax credit. Commenters said this would protect providers that render services to such enrollees during the grace period. A few commenters were also concerned about the timing of claims, and suggested that QHP issuers be obligated to pay claims based on the date the service was rendered, and not the date the claim was submitted.

Response: We understand that pended claims increase uncertainty for providers and increase the burden of uncompensated care. The obligation to pay all appropriate claims established in the proposed rule was intended to protect providers during an extended grace period. However, given the significant concerns regarding premium increases and the potential tax liability to consumers, we were concerned that this approach did not strike the right balance. Because we share providers' concerns about incurring claims during the grace period that are not

ultimately paid, we now establish in §156.270(d)(3) of the final rule that QHP issuers notify providers who submit claims for services rendered during the second and third months of the grace period that any such claims will be pended, and potentially not reimbursed by the QHP issuer if the individual does not settle outstanding premium payments. We believe that there are technology-based approaches to provide this notification. We also clarify in §156.270(d)(1) that the application of the grace period to claims is based on the date the service was rendered, and not the date the claim was submitted.

Comment: Some commenters suggested that the 3-month grace period proposed in §156.270(d) should be shorter, and that HHS refrain from establishing additional rules. Other commenters suggested extending the grace period to 6 months, at least for the first few years.

Response: As stated in the proposed rule, section 1412(c)(2)(B)(iv)(II) of the Affordable Care establishes that QHP issuers "receiving advance payments of the premium tax credit with respect to an individual enrolled in the plan shall… allow a 3-month grace period for non-payment of premiums before discontinuing coverage"(76 FR 41902). We do not believe that the statute provides the flexibility to alter the grace period timeframe.

Comment: Several commenters requested clarification on whether the grace period described in proposed §156.270(d) would be triggered by a full non-payment of premium or a partial non-payment of premium.

Response: The 3-month grace period applies whenever the QHP issuer has received payment of less than the full amount of the enrollee's share of the premium for a given month. It is our understanding that issuers have varying practices related to the triggering of a grace period, with some issuers initiating a grace period for any payment that is not the full premium and others initiating a grace period only if the individual has not submitted an amount above

some threshold. However, in order to be consistent with policy related to the advance payments of the premium tax credit, the enrollee must pay the full amount of his or her portion of the premium or the grace period would be triggered.

Comment: Several commenters voiced concerns about the potential for gaming during the grace period described in proposed §156.270(d). Commenters suggested that we take action to prevent people from habitually paying 9 months of premiums, stopping premium payment for 3 months, and then enrolling in a new QHP to start the process over again. Commenter suggestions included: requiring payment of all outstanding premiums before enrollees can change issuers, enroll in a different QHP, or re-enroll in a QHP; establishing a 60-day waiting period for individuals who have been terminated for coverage due to non-payment of premiums but seeking re-enrollment in another QHP; allowing issuers to seek reimbursement for claims paid during the grace period from enrollee after termination; issuing a late enrollment penalty or establish a pre-existing condition exclusion period for individuals seeking re-enrollment after termination due to non-payment of premiums; prohibiting enrollment in a QHP until the following open enrollment period; prohibiting someone who has been terminated due to non-payment of premiums from qualifying for a special enrollment period later in the year; imposing penalties for repeat offenders, increasing premiums; allowing QHP issuers to collect the first and last month's premium at the time of application; and finally, limiting grace periods to one year. Other commenters recommended that States have the flexibility to establish their own protections against opportunistic consumer behavior.

Response: We did not adopt the recommendations regarding non-issuance of coverage for individuals who have outstanding premium payments for a previous QHP because we believe that there are implications for rescissions, guaranteed issue, and pre-existing condition policies.

HHS will continue to explore options for incentivizing appropriate use of the grace period, either through future rulemaking or in the context of general insurance market reforms. We will also consider the implications for automatic redeterminations and reenrollment in instances where individuals have had their coverage terminated for non-payment of premiums. Gaming will not only affect issuers, but also represents potential for misuse of the advance payments of the premium tax credits. Given the compelling Federal financial stake in grace period, HHS will monitor this issue moving forward and will continue to work on the development of policies to prevent misuse of the grace period.

Comment: Many commenters voiced support of the continued issuance of advance payments of the premium tax credit on behalf of enrollees during the 3-month grace period, as proposed in §156.270(e). Some commenters suggested that if QHP issuers were allowed to terminate coverage retroactively, then QHP issuers should be directed to return the advance payments of the premium tax credits.

Response: We have maintained the proposed rule policy that QHP issuers must continue to receive advance payments of the premium tax credit being paid on behalf of an enrollee in a grace period. In addition, we included in §156.270(e)(2) an instruction for QHP issuers to return advance payments of the premium tax credit for the second and third months of the grace period for individuals who exhaust the grace period without paying outstanding premiums, because such individuals will have their coverage terminated retroactively to the end of the first month of the grace period. We note that, consistent with section 36B of the Code, individuals may owe a tax liability as a result of advance payments of the premium tax credit paid on their behalf during a month in which they did not pay their portion of the premium. Under the final rule, individuals will have a liability as a result of the advance payment of the premium tax credit for the first

month of the grace period if they never pay their portion of the first month's premium. If an individual exhausts the grace period without paying all outstanding premiums, QHP issuers can terminate coverage retroactive to the end of the first month of the grace period and deny claims that were pended. An issuer who terminated coverage in this fashion would be obligated to return the advance payments of the premium tax credit made on behalf of the individual for the second and third months of the grace period.

Comment: Some commenters requested clarification of the proposed policy in §156.270(g) regarding whether a partial payment could extend the grace period once it has already been triggered, or if only full payment of all outstanding premiums would allow an individual to resolve a grace period. Commenters supported the resetting of the grace period only when all outstanding payments are made.

Response: The grace period may only be reset be if an individual has paid all outstanding premiums. We believe that a "rolling" grace period that moves the initial date of the grace period in correlation with any payment made by an individual would be not only confusing to consumers but administratively burdensome, particularly in light of the revised payment policy described in paragraph (d). Therefore, in this final rule, we have added language to clarify this policy in §156.270(g). Once a grace period has been initiated by a QHP issuer, the individual has three months to settle all outstanding premium payments, at which time the grace period is either resolved and pended claims are paid or the individual's coverage is terminated.

Comment: Commenters requested clarification on the proposed policy in §156.270(g) regarding whether a QHP issuer could terminate coverage retroactively to the last date of payment, or whether the termination was prospective from the end of the 3-month grace period.

Commenters also requested clarification regarding how advance payments of the premium tax credit and payments to providers would be reconciled if the date of termination were retroactive.

Response: We clarify in final §156.270(g) that if an individual exhausts the grace period without settling all outstanding premium payments, then the QHP issuer can terminate coverage retroactively to the first day of the second month in the grace period. We understand that many States allow issuers to terminate to the last paid date of coverage. In addition, HHS issued rules concerning rescissions of health insurance coverage, under which issuers are permitted to cancel coverage retroactively due to a failure to timely pay premiums (PHS Act section 2712; 45 CFR §147.128). However, the final Exchange standards for QHP issuers add more consumer protections than the generally applicable PHS Act's standards. During the first month, full coverage will be provided and the QHP issuer will be able to keep the advance payment of the premium tax credit. As a result, we treat the last day of the first month of the grace period as the "last paid date." We note that the enrollee may be obligated to repay the advance payment of the premium tax credit for the first month in the form of an additional tax liability if the individual does not pay the enrollee's portion of the premium. For purposes of claims payment, the QHP issuer must treat the first month of the grace period as if the full premium has been paid. However, the QHP issuer may pursue collection of the individual's portion of the premium; if the individual pays the unpaid enrollee portion of the premium, the individual would retain the potential to be eligible for the premium tax credit for that month.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.270 of the proposed rule, with the following modifications: we added paragraph (b)(1) to note that a QHP issuer must provide the enrollee with a notice of termination of coverage at least 30 days prior to effectuating

termination. We added paragraph (b)(2) to clarify that the QHP issuer must give reason for termination in a notice. We have also amended the proposed policy regarding the statutory 3-month grace period for individuals receiving advance payments of the premium tax credit. As described in paragraphs (d) through (g), QHP issuers will now be directed to pay appropriate claims in the first month only of the grace period, and will be able to pend claims in the second and third months. QHP issuers must notify providers who submit claims that an enrollee is in the second or third month of the grace period and that a claim may be denied if the outstanding premiums are not paid in full. Finally, QHP issuers must retain advance payments of the premium tax credit made on behalf of an individual for the first month, and must return such payments for the second and third months to the Department of the Treasury. Finally, we redesignated proposed paragraphs (g) and (h) as (h) and (i), respectively, to accommodate other changes to this section.

m. Accreditation of QHP issuers (§156.275)

In §156.275, we proposed to codify the statutory provision that a QHP issuer be accredited on the basis of local performance in each of the nine categories listed in the Affordable Care Act, where "local performance" means performance of the QHP issuer in the State in which it is licensed. We further specified that a QHP issuer must be accredited by an entity recognized by HHS. We also proposed that a QHP issuer must obtain its accreditation within a time period established by the Exchange under §155.1045.

Comment: In general, commenters supported accreditation as a condition of QHP certification. One commenter voiced concern over the over the cost of private accreditation and the impact on participation of issuers in Exchanges. Commenters also suggested additional areas that HHS should include in standards for accreditation beyond those specified in the proposed

rule, including specific clinical measure sets that should be included, among others. Another commenter asked that new accreditation models be reviewed that are specifically developed for the individual and small group market. One commenter asked for clarification if States would be able to establish more stringent accreditation standards beyond the Federal minimum.

Response: While we understand that accreditation can be a costly and resource-intensive process for issuers, it is established in the Affordable Care Act for certification of QHPs. At this time we are also not adding any additional standards for accreditation beyond what is specified in the Affordable Care Act. The Affordable Care Act is clear as to which criteria should be included in accreditation standards and we are codifying the statute in this regard. We clarify that Exchanges may impose accreditation standards that are more stringent than those contained in the Affordable Care Act.

Comment: Several commenters suggested specific entities that should be recognized by HHS and asked that more than one accrediting entity be recognized. Other commenters asked HHS to specify which accreditation entities would be selected and requested including both private and public entities.

Response: We will be issuing future rulemaking to establish a process by which accrediting entities will be recognized. Comments that requested specific products be considered for accreditation are beyond the scope of this rule.

Comment: A commenter did not support the proposal to direct issuers to authorize the release of their accreditation survey.

Response: We codify the obligation that issuers authorize the release of their accreditation survey to the Exchange and HHS. We believe that this is necessary to monitor the accreditation of QHP issuers beyond what can be learned from a simple reporting of

accreditation status. We are also exploring the extent to which data submitted on the accreditation survey may be used to fulfill quality reporting standards, which may help alleviate potential reporting burden on Exchanges and issuers.

Comment: In general, commenters supported establishing a timeline for accreditation of QHP issuers under proposed §156.275(b). However, several commenters disagreed with our proposal to allow Exchanges to set the timeline and requested that HHS establish a Federal timeline for accreditation that all Exchanges must follow. Commenters also provided recommendations on appropriate accreditation timelines for HHS to establish, ranging from one to several years. Other commenters suggested that there should be a transition period for new plans to become accredited.

Response: The Affordable Care Act, at section 1311(c)(1)(D)(ii) clearly provides for the Exchange to establish the timeframe. Consistent with the statute, we believe that Exchanges are in the best position to determine the accreditation timeline for QHP issuers operating in their States. Exchanges are familiar with local market conditions and the needs of their constituents. Therefore, we are maintaining the regulation text as proposed.

Summary of Regulatory Changes

We are finalizing §156.275 as proposed.

n. Segregation of funds for abortion services (§156.280)

In §156.280, we proposed to implement section 1303 of the Affordable Care Act by codifying the statutory provisions. This codification includes the non-discrimination clause for providers and facilities, a voluntary choice clause for issuers with respect to abortion services, the standards for the segregation of funds for QHP issuers that elect to cover abortion services for which public funding is prohibited, and the associated communication standards related to

such services. We solicited comment on the related model guidelines issued by HHS and the Office of Management and Budget on September 20, 2010[14], noting that we intended the model guidelines to serve as the basis for the final rule.

Comment: A large number of commenters offered feedback on proposed §156.280. Of these, many expressed general support for or opposition to abortion coverage in Exchanges. A number of commenters supported specific provisions of the proposed rule and recommended that they be finalized; for example, the voluntary choice provision for QHP issuers and the provision on the applicability of emergency services laws. Conversely, a few commenters recommended changes to the proposed provisions – such as that each Exchange be directed to include one QHP that covers non-excepted abortion services. A few commenters requested that HHS provide additional technical guidance on the provisions in section 1303 of the Affordable Care Act; for example, a few commenters suggested specific clarifications to the pre-regulatory model guidelines that describe high-level principles for QHP issuers' segregation plans, while other commenters recommended that Exchanges be directed to review the actuarial value of abortion coverage calculated by QHP issuers. Commenters also recommended that HHS clarify the provisions regarding separate payments for non-excepted abortion and all other services, specifically whether QHP issuers must collect separate payments from all enrollees or only from those receiving Federal financial assistance, whether QHP issuers may satisfy the separate payment provision by providing each enrollee with an itemized bill, and whether an enrollee's coverage would be terminated for failure to comply with the separate payment provision. A few commenters requested that HHS strengthen anti-discrimination protections for providers or expand the conscience protection. Finally, a few commenters raised concerns regarding provisions that HHS believes are addressed elsewhere in the final rule, such as privacy of

[14] Available at: http://www.whitehouse.gov/sites/default/files/omb/assets/financial_pdf/segregation_2010-09-20.pdf.

individuals' QHP selections, and accessibility standards and other protections for QHP notices and plan information.

Response: We considered the comments received on this section, and are finalizing the provisions of proposed §156.280 without modification, with the exception of finalizing the pre-regulatory model guidelines on issuer segregation plans released by HHS and the Office of Management and Budget.[15] Where future guidance is issued on this section, these comments will be taken into account.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.280 of the proposed rule, with the following modifications: we redesignated paragraph (e)(5)(ii) as (e)(5)(iv). In new paragraphs (e)(5)(ii) and (e)(5)(iii), we codified the pre-regulatory model guidelines on segregation of funds published by the Office of Management and Budget and the Assistant Secretary for Financial Resources as proposed.

o. Additional standards specific to the SHOP (§156.285)

In §156.285, we proposed rating and premium payment standards for QHP issuers participating in the SHOP, including a proposal that the QHP issuer accept aggregated premiums, abide by the rate setting timeline established by the SHOP, and charge the same contract rate for a plan year. We also proposed that QHP issuers must accept and enroll applicants during the annual open enrollment period described in §155.725 and the special enrollment periods described in §155.420 (excluding paragraphs (d)(3) and (d)(6)), and they must ensure effective dates of coverage in accordance with §155.410(c). We solicited comment on whether to direct QHPs in the SHOP to allow employers to offer dependent coverage.

[15] Available at: http://www.whitehouse.gov/sites/default/files/omb/assets/financial_pdf/segregation_2010-09-20.pdf.

We also proposed that QHP issuers abide by the SHOP enrollment timeline process standards, including the standards that QHP issuers must frequently accept electronic transmission of enrollment information from the SHOP, provide all new enrollees with the enrollment information package, and provide qualified employers and employees with the summary of cost and coverage document. We further proposed that QHP issuers reconcile enrollment files with the SHOP at least monthly. Additionally, we proposed that QHP issuers abide by the SHOP standards for acknowledgement of the receipt of enrollment information and issue qualified employees a policy that aligns with the qualified employer's plan year and contract.

We also proposed general standards related to termination of coverage in the SHOP that are largely similar to the standards for the Exchange with respect to their enrollees from the individual market. We noted that the QHP issuer would be directed to provide the qualified employers and employees with a notice of termination of coverage of enrollees and QHP non-renewal to ensure that the qualified employer is aware of the changes in coverage for its employees and the availability of coverage in the SHOP. We indicated that a QHP issuer must terminate all enrolled qualified employees of the withdrawing employer if the employer chooses to stop participating in the SHOP.

Comment: In response to proposed §156.285(b), one commenter recommended that the employer, and not the SHOP, establish the specific standards and dates for open enrollment and special enrollment periods.

Response: We believe that States should have the flexibility in establishing their enrollment periods based on the specific market and employer circumstances in the State, as it often does today for the small group market.

Comment: One commenter recommended that proposed §156.285(b)(2) specify that employees who enroll during a special enrollment period should be allowed to purchase coverage at the same rates as those employees who enrolled during the annual open enrollment period for that plan year.

Response: We note that §156.210 directs an issuer to set rates for an employer that will remain in effect for the employer's entire plan year.

Comment: One commenter suggested that the preamble text, which states that the rule would direct issuers to provide all new enrollees with an enrollment information package as described in §156.265(e), is inconsistent with the proposed regulation text in §156.285(c)(3), which states that the enrollment information package is described in §156.265(f).

Response: We have modified the final rule to correctly reference §156.265(e).

Comment: One commenter requested clarification of the definition of a QHP for the SHOP.

Response: We note that all of the standards in part 156, including definitions, pertaining to QHPs also apply to the QHPs offered through the SHOP in the small group market unless the regulation text explicitly indicates that a specific standard pertains only to QHPs offered to qualified individuals, or are otherwise exempted.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.285 of the proposed rule, with the following modifications in conformance with changes to part 155 subpart H: in new paragraph (b)(3) we clarified that a SHOP must offer an enrollment period to a newly qualified employee who becomes qualified outside of the initial or annual open enrollment period. In new paragraph (b)(4) we established that a SHOP must conform to the effective dates of coverage described in

§156.260 and §155.720. In new paragraph (e) we clarified that QHP issuers participating in the SHOP may not impose minimum participation rules with respect to a QHP unless the SHOP authorizes the minimum participation rule in accordance with 155.705(b)(10). Finally, we made a limited number of technical changes to clarify the language in this section.

p. Non-renewal and decertification of QHPs (§156.290)

In §156.290, we proposed standards for QHP issuers that voluntarily do not renew participation of a QHP in the Exchange, including notification, benefit coverage standards, and reporting standards. Specifically, we proposed to direct QHP issuers that do not renew QHP participation to provide written notice to each enrollee. We solicited comment on the potential content of the non-renewal notice and any other information that we should consider including. We also proposed that if an Exchange decertifies a QHP, the QHP issuer must terminate coverage for enrollees only after the Exchange has notified the QHP's enrollees as described in §155.1080 and enrollees have had the opportunity to enroll in other coverage. We requested comment on the extent to which enrollees should continue to receive coverage from a decertified plan.

Comment: One commenter recommended that HHS or Exchanges attach penalties to the decision not to seek recertification described in proposed §156.290(a), such as barring the QHP from participating in the Exchange for one year following the non-renewal. Conversely, a few commenters requested that HHS prohibit Exchanges from imposing penalties or sanctions on plans that voluntarily non-renew.

Response: HHS lacks authority under the Affordable Care Act to impose any penalties for non-renewal of a QHP in an Exchange. Exchanges may take varied approaches to voluntary

non-renewal; for example, some Exchanges may establish criteria for re-entry, while other Exchanges may utilize the standard certification process.

Comment: One commenter recommended that the final rule direct QHPs that choose not pursue recertification to complete data reporting 6 to 12 months after exiting the market.

Response: Obtaining data from non-renewing QHPs will be important for Exchanges. We note that §156.290(a)(3) expressly obligates a non-renewing QHP to complete its reporting through the end of the plan or benefit year.

Comment: A few commenters suggested that HHS establish more advanced notice for non-renewal than the proposed deadline of September 15th.

Response: We believe that a deadline of September 15th is sufficiently far in advance of the annual open enrollment period to provide adequate notice for Exchanges and enrollees. Accordingly, we are finalizing that deadline as proposed.

Comment: Several commenters suggested that HHS direct QHPs to notify participating providers of a decision not to renew. These commenters further suggested that the QHP pay all incurred claims until participating providers have been notified.

Response: Section 156.290 of the final rule establishes that QHPs that choose not to pursue recertification must cover benefits for enrollees for the duration of the plan or benefit year. Similarly, QHPs must pay all claims incurred while certified and participating in the Exchange, subject to the terms and conditions of the QHP's contracts with providers. While participating providers have a significant interest in a QHP's decision not to seek recertification with the Exchange, we believe that establishing a standard for QHP issuers to notify participating providers would impose a significant burden on QHPs. Therefore, we are not adding such a standard in the final rule.

Summary of Regulatory Changes

We are finalizing §156.290 as proposed.

q. Prescription drug distribution and cost reporting (§156.295)

In accordance with section 6005 of the Affordable Care Act, we proposed in §156.295 that QHP issuers provide the following information related to prescription drug distribution--(1) the percentage of all prescriptions that were provided under the contract 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, broken down by pharmacy type, that is paid by the QHP issuer or pharmacy benefit manager (PBM) under the contract; (2) the aggregate amount, and the type of rebates, discounts, or price concessions, with certain exceptions, that the PBM negotiates that are attributable to patient utilization under the plan, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed; and (3) the aggregate amount of the difference between the amount the QHP issuer pays the PBM and the amount that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed. We sought comment on how a QHP issuer whose contracted PBM operates its own mail order pharmacy can meaningfully report on element (3). We also requested comment on potential definitions for "rebates," "discounts" and "price concessions"; and noted that we were considering using the term "direct and indirect remuneration," to encompass these various arrangements. We also requested comment on our proposed definition of PBM and whether we should define PBMs as any entities that perform specific functions on behalf of a health insurance issuer. We sought comment on how to minimize the burden of these reporting standards.

Finally, we also proposed to codify the statutory penalties for noncompliance, including $10,000 per day that information is not provided; contract termination if the information is not reported within 90 days of the deadline; and $100,000 per piece of false information provided.

Comment: In response to proposed §156.295(a)(1) – (3) and the discussion in the preamble to the proposed rule, many commenters requested clarification of key terms used in this section, such as "PBM," "generic drug," "bona fide service fees," and "rebates, discounts, or price concessions." One commenter requested that stakeholders have future opportunities to review and comment on the technical specifications of this section. Some commenters supported the proposed definition of "PBM," while others recommended a broader definition that would encompass all entities that provide management services but do not negotiate directly with manufacturers. A few commenters requested clarification of this definition with respect to medical benefit and physician-administered drugs. With respect to the definition of "generic drug," commenters offered numerous alternate definitions that HHS could adopt, including the definition provided in the Social Security Act, single source versus multiple source drugs, or therapeutically and bioequivalent. Several commenters responded to HHS' request for comment on the definition of "rebates, discounts, or price concessions." Some urged HHS to codify the statute as written, or proposed specific definitions for these terms. Other commenters recommended use of the term "direct and indirect remuneration" and recommended that CMS maintain consistent definitions across the Exchange and the Medicare program.

Response: Section 6005 of the Affordable Care Act includes similar standards for both the Medicare program and the Exchange. We believe that many of the entities and issuers that will report these data may participate in both programs. Therefore, we will align definitions with the Medicare program to the extent possible. We note that we are maintaining the proposed

definition of "PBM", which we believe encompasses a sufficiently broad spectrum of entities and activities. We are similarly maintaining the proposed interpretations of "generic drug" and "rebates, discounts, or price concessions." Finally, we are revising the description of "bona fide service fees" to better align with the definition included by the Medicare program in a proposed rule released on October 11, 2011, and to provide for greater flexibility with respect to this definition, given that bona fide services are subject to change as new ones are developed or other bona fide services are discontinued. Accordingly, we are not finalizing the specific examples of bona fide service fees included in the proposed rule.

As we noted in the preamble to the proposed rule, we intend to clarify these standards through forthcoming guidance. We anticipate continuing to work with stakeholders to refine these standards.

Comment: One commenter requested that HHS clarify the standard in proposed §156.295(a)(1) that QHP issuers report generic dispending rates "broken down by pharmacy type."

Response: We clarify that paragraph (a)(1) directs QHP issuers to report generic dispensing rates separately for each of four types of pharmacies: mail order pharmacies, independent pharmacies, supermarket pharmacies, and mass merchandiser pharmacies.

Comment: In response to HHS' request for comment on how a QHP issuer whose contracted PBM operates its own mail order pharmacy can meaningfully report on the aggregate difference between what the issuer pays the PBM and what the PBM pays the pharmacy, several commenters suggested that mail order pharmacies owned by PBMs do not present unique challenges with respect to this reporting activity.

Response: As noted in the preamble to the proposed rule, we expect to issue further guidance on this section, and will continue to engage stakeholders to refine these reporting activities.

Comment: In response to HHS' request for comment on how to minimize the burden associated with proposed §156.295(a)(1) – (3), several commenters recommended that HHS limit the collection of information to those data elements listed in the Affordable Care Act. Commenters also suggested that HHS harmonize reporting standards across programs to the extent possible, such as by using the PDE reporting format currently used in the Medicare Part D program. Multiple commenters recommended that HHS monitor compliance with this section through audits only, either of QHP issuers or of PBMs.

Response: We clarify that HHS will only collect those data elements specified in the Affordable Care Act. We further intend to be consistent across programs to minimize burden and promote consistency, and are aligning the definitions of key terms used in this section with the Medicare Part D program. We expect to provide additional detail on the exact format and content of this reporting in future guidance.

Comment: In response to the reporting standards identified in proposed §156.295(a), a few commenters requested more detailed information on why HHS needs to receive the data and how the data will be used. Conversely, some commenter favored greater transparency of prescription drug cost information and recommended that the information be reported to the Exchange.

Response: Section 6005 of the Affordable Care Act directs HHS to collect the data elements listed in the statute. We note that the Affordable Care Act limits the disclosure of these

data, which we codify in paragraph (b). At this time we are still refining the process for reporting and uses for these data, and expect to provide additional guidance on this section in the future.

Comment: A few commenters raised concerns about QHP issuers' ability to comply with the reporting standards in proposed §156.295(a)(1) through (3), noting that current contracts between issuers and PBMs do not typically cover these data elements.

Response: We believe that issuers and PBMs will have sufficient time to renegotiate or modify these contracts before reporting becomes necessary.

Comment: One commenter recommended that HHS establish some flexibility in the application of penalties to accommodate delays in the realization of price concessions and exceptional circumstances such as IT failure or human error.

Response: HHS intends to issue further guidance on these reporting standards, including how the statutory penalties may be applied.

Summary of Regulatory Changes

We are finalizing the provisions proposed in §156.295 of the proposed rule, with the following modification: in paragraph (a)(2)(i) we revised the description of "bona fide service fees" to better align with the definition included by the Medicare program in a proposed rule released on October 11, 2011, published at 76 FR 63018, and to provide for greater flexibility with respect to this definition, given that bona fide services are subject to change as new ones are developed or other bona fide services are discontinued.

1. Subpart F - Consumer Operated and Oriented Plan Program.

Definitions (§156.505).

Section 156.505 sets forth definitions for terms that are used throughout subpart F for the CO-OP program. In the final rule, "Establishment of Consumer Operated and Oriented Plan

(CO-OP) Program (76 FR 77392), we revised the definitions of several terms to remove references to the "Establishment of Exchanges and QHPs" rule (76 FR 41866), because it had not yet been finalized. We also added definitions for several terms as they were proposed in the rule, "Establishment of Exchanges and QHPs" (76 FR 41866), because those terms were referred to within the revised definitions.

In the CO-OP Program Final Rule, we stated that once the "Establishment of Exchanges and QHPs" rule (76 FR 77392) was finalized, we would revise the definitions in section 156.505 to incorporate the definitions adopted in the new part 155. Consistent with this intent, we have revised the definitions for the terms "CO OP QHP," "Exchange," "individual market," "issuer," "small group market," "SHOP," and "State" from the CO-OP Program Final Rule to reference the definitions in the new part 155. As explained later in this preamble, the changes in this section are being issued on an interim basis. These revisions ensure that the definitions used in subpart F of section 156 are consistent with the definitions in the new part 155. We also removed the definitions of "group health plans," "health insurance coverage," "small employer," "qualified employer," and "QHP" because these terms are no longer referenced in the aforementioned definitions.

We made a technical change to section 156.510(b)(2)(ii). When referring to an applicant that "has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that is also a sponsor for a pre-existing issuer," we inadvertently used the defined term "sponsor." Our intent was to refer to an entity that sponsors a pre-existing issuer and not an entity that serves as a CO-OP's sponsor. Therefore, we revised this provision to refer to an applicant that "has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that also sponsors a pre-existing issuer."

C. Part 157—Employer Interactions with Exchange and SHOP Participation

In part 157, we proposed standards that address qualified employer participation in SHOP. Also, we briefly outlined employer interactions with Exchanges related to the verification of employees' eligibility for qualifying coverage in an eligible employer-sponsored plan.

1. Subpart A—General Provisions.

Subpart A outlines the basis and scope for part 157 and defines terms used throughout part 157.

a. Basis and scope (§157.10)

In §157.10, we proposed the general statutory authority for the proposed regulations and outlined the scope of part 157, which is to establish the standards for employers in connection with Exchanges. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Definitions (§157.20)

In §157.20, we proposed definitions for terms used in part 157 that need clarification. The definitions presented in §157.20 are taken directly from the statute or based on definitions we proposed in part 155 or part 156. For instance, we stated that the terms "qualified employer," "qualified employee" and "small employer" have the meaning given to the terms in §155.20.

We did not receive specific comments on this section and are finalizing the provisions as proposed. Furthermore, we are finalizing the definitions proposed in §157.20 of the proposed rule without modification.

2. Subpart C – Standards for Qualified Employers

Subpart C of this part outlines the general provisions for employer participation in SHOPs. As we noted in the preamble to the proposed rule, this subpart substantially mirrors and complements subpart H of part 155.

a. Eligibility of qualified employers to participate in the SHOP (§157.200)

In §157.200, we proposed the standards for an employer that seeks to offer health coverage to its employees through a SHOP. We proposed that only qualified employers may participate in a SHOP. In the preamble to the proposed rule, we noted that some small employers may have employees in multiple States or SHOP service areas, referencing proposed §155.710, which would allow multi-State employers flexibility in offering coverage to their employees. We did not receive specific comments on this section and are finalizing the provisions as proposed.

b. Employer participation process in the SHOP (§157.205)

In §157.205, we proposed the process for employer participation in the SHOP. Specifically, we proposed that a qualified employer make available QHPs to employees in accordance with the process developed by the SHOP pursuant to §155.705, and that a qualified employer participating in a SHOP disseminate information to its employees about the methods for selecting and enrolling in a QHP. We also proposed that a qualified employer submit premium payments according to the process proposed in §155.705. Additionally, we proposed that a qualified employer must provide an employee hired outside of the initial enrollment or annual open enrollment period with specific information.

We further proposed that a qualified employer provide the SHOP with information about individuals or employees whose eligibility to purchase coverage through the employer has changed. We also proposed that a qualified employer adhere to the annual employer election

period to change program participation for the next plan year. In §155.725, we proposed that a qualified employer may begin participating in the SHOP at any time.

Finally, we proposed that if a qualified employer remains eligible for coverage and does not take action during the annual employer election period, the employer would continue to offer the same plan, coverage level or plans selected the previous year for the next plan year unless the QHP or QHPs are no longer available. We invited comments regarding the feasibility of the processes established in this section and the implications for small employers and their employees.

Comment: Some commenters requested that the final rule direct the SHOP to create a specific timeline for employers to notify their employees regarding their coverage options. Some commenters strongly supported the suggestion that the SHOP create a toolkit to help qualified employers explain the enrollment process and the choices available to employees.

Response: SHOPs may support employers through electronic means and through informational packages in communicating with their employees about available coverage options, and note that nothing in this section would preclude a SHOP from developing such resources. We do not codify an employer notification standard because we think it unnecessary.

Comment: One commenter stated that HHS should clarify that qualified employers offering coverage through the SHOP should be able to choose which QHPs they will offer their employees rather than allowing SHOPs to potentially decide employer offerings.

Response: Section 1311 of the Affordable Care Act directs a SHOP to, at a minimum, offer coverage to qualified employees as follows: qualified employers select a cost sharing level, within which qualified employees may select any available QHP. We recognize the need to balance the extent of employer and employee choice against the potential for risk selection

resulting from those choices. As discussed more fully in the comment and response section of §155.705(b)(2) and (3), we have neither specified nor restricted the range of additional employer options a SHOP may offer. Therefore, we are finalizing the provisions of this section as proposed with minor edits for better clarity and precision.

Summary of Regulatory Changes

We are finalizing the definitions proposed in §157.205 of the proposed rule with the following modification: in paragraph (e)(1) we clarify that a SHOP must offer an enrollment period to a newly qualified employee beginning on the first day of such employee becoming qualified.

## IV. Waiver of Proposed Rulemaking

We ordinarily publish a notice of proposed rulemaking in the **Federal Register** and invite public comment on the proposed rule. The notice of proposed rulemaking includes a reference to the legal authority under which the rule is proposed, and the terms and substance of the proposed rule or a description of the subjects and issues involved. This procedure can be waived, however, if an agency finds good cause that a notice-and-comment procedure is impracticable, unnecessary, or contrary to the public interest and incorporates a statement of the finding and its reasons in the rule issued.

Based on the comments that we received on the Exchange establishment and eligibility proposed rules, we believe that there are new options and specific standards that should be implemented in connection with eligibility determinations. Specifically, we finalize here the ability of an Exchange to fulfill minimum functions without making eligibility determinations for Medicaid or CHIP, advance payments of premium tax credits, or cost-sharing reductions, provided that certain conditions and performance standards are met. As this option for a

bifurcation of the responsibility to determine eligibility was not included in the proposed rule, the proposal also did not address the regulatory framework and standards necessary under this option to achieve a system of streamlined and coordinated eligibility and enrollment, the major goal underpinning our proposals in the Exchange eligibility proposed rule (76 FR 51204). In this rule, in part 155 subpart D in the sections identified below, we outline the options and approach to maintain the seamless consumer experience while allowing States to design the eligibility process to best match their current systems and capacity and State policy goals.

A compliant system for eligibility determination is critical to the establishment and implementation of Exchanges. In this final rule, we provide additional flexibility for how and by which eligibility for various insurance affordability programs will be made than was proposed in the Exchange proposed rules released in the summer of 2011. We also outline certain timeliness standards and agreements to permit a non-integrated approach to eligibility determination that still affords applicants a seamless path to enrollment in coverage but would not increase administrative burden and costs.

In addition, we finalize on an interim basis certain eligibility standards for cost-sharing reductions for multi-state households, Exchange timeliness standards for eligibility determinations, Exchange timeliness standards for administration of cost-sharing reduction and advance payments of premium tax credit, and a limited exception to the general verification rules for individuals in special circumstances. Although the proposed rule did not clearly and consistently address these timeliness provisions, commenters indicated the importance of such standards and we recognize the importance of providing finality for these standards at this time. We finalize an interim provision, at §155.315(g), to provide a process by which the Exchange must complete verifications of information for applicants without documentation; this interim

provision is also included in the Medicaid final rule. This provision was not proposed but several commenters raised the need for such a limited exception to the verification procedures otherwise required in subpart D. Further, HHS and CMS received comments in response to the Exchange Eligibility proposed rule and the Medicaid proposed rule related to better alignment of the Exchange and Medicaid and CHIP programs. Interim final provisions to set parameters for cooperation and coordination of these programs are included here at §155.345(a) and (g).

The process for approval of State-based Exchanges must begin prior to January 1, 2013, a date by which HHS must approve (or conditionally-approve) States-based Exchanges for the 2014 coverage year. States that elect to establish an Exchange must make and implement critical decisions in order to seek approval of a State-based Exchange, including those about how eligibility determinations will be made. As they make these decisions, it is essential that States know the standards and necessary agreements associated with the new bifurcation alternatives for making eligibility determinations, the additional parameters for cooperation and alignment with Medicaid and CHIP programs, and the new rules governing Exchange eligibility determinations. Like the new bifurcation options described above, the new standards associated with Exchange determinations are also integral to developing and establishing an Exchange – and the systems to support it – in order to meet the January 1, 2013 deadline for HHS approval. For example, the timeliness and verification standards for Exchange eligibility determinations need to be part of the eligibility determination system that is developed. Similarly, the timeliness standards associated with administration of cost sharing reductions and premium tax credits are necessary to include in the initial establishment of Exchange systems. Accordingly, we believe we need to finalize these provisions as soon as possible to provide States the information they need for Exchange establishment.

As a result, based on the comments to the 2011 Exchange proposed rules regarding these policies, we believe it would be contrary to the public interest to delay issuing new eligibility determination and timeliness standards rules. Further, providing public notice and additional comment periods for these policies would not provide States with sufficient lead time to take advantage of and incorporate these additional policies, prepare their State Exchange Blueprints, and complete the State Exchange readiness assessments process as set out in the proposed and this final rule. In light of the timing constraints, we are soliciting additional comment and issuing as interim final the following provisions:

- §155.300(b) – Related to Medicaid and CHIP regulations;
- §155.302 – Related to options for conducting eligibility determinations;
- §155.305(g) – Related to eligibility standards for cost-sharing reductions;
- §155.310(e) – Related to timeliness standards for Exchange eligibility determinations;
- §155.315(g) – Related to verification for applicants with special circumstances;
- §155.340(d) – Related to timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions; and
- §155.345(a) and §155.345(g) – Related to agreements between agencies administering insurance affordability programs.

We also received comments on the Exchanges establishment proposed rule regarding the need for performance and training standards that should be developed by HHS or required by HHS for agent and brokers who are assisting individuals with applications for insurance affordability programs. The proposed rule discussed and solicited comment about how to incorporate agents and brokers in the process of enrolling qualified individuals and qualified

employers through the Exchange; provisions to achieve that policy goal are finalized in this rule in light of the comments received to the proposed rule.[16] We did not propose or solicit comment on specific standards related to the provision of application assistance by agents and brokers. To provide useful assistance, agents and brokers should be fully aware of the complex eligibility and verification standards that will be used to determine eligibility for advance payment of premium tax credits and cost-sharing reductions. Also, in connection with this assistance, agents and brokers may gain access to a potential enrollee's income information, including access to sensitive tax data. Because the proposed rule did not apply training or performance standards to agents and brokers in connection with providing assistance to applicants, we did not address the regulatory framework supporting standards to ensure that agents and brokers are cognizant of the eligibility determination standards and process, maintain the confidentiality of such data, and operate in a manner that support their access to such data. In §155.220, we describe these standards in more detail and outline their importance and connection to privacy and security standards described elsewhere in this rule.

Agent and brokers, where permitted to operate in a State, may serve an important role in assisting individuals in applying for coverage in the Exchange and with assisting individuals in gaining access to health insurance affordability programs. Because open enrollment for Exchanges will begin on October 1, 2013, and Exchanges require lead time to develop and implement privacy and security standards, agreements, training programs for agent and brokers, as well as systems to support agents and brokers working with Exchanges. As a result, we find that providing public notice and additional comment periods for these policies would not provide States with sufficient lead time to take advantage of and incorporate these additional policies prior to Exchange approval under the processes as set out in the proposed and this final rule. In

[16] We direct attention to §155.220(a)(2) and the preamble for that section for a more detailed discussion.

light of the timing constraints, we are also soliciting additional comment and issuing as interim final the following provision:

- §155.220(a)(3) – Related to the ability of a State to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs.

For the reasons stated above, we find good cause to waive the notice of proposed rulemaking and to issue these specific portions of this final rule on an interim basis. We are providing a 45-day public comment period in connection with these provisions.

Finally, this final rule makes a small number of technical changes to the provisions relating to CO-OPs, 45 C.F.R. part 156 subpart F. We find there is good cause to waive notice and comment rulemaking for these changes because soliciting comment on them is unnecessary. These changes do not alter the substance of the CO-OP regulations and are therefore being finalized in this rule. As discussed the preamble above, they are being made principally to minimize duplicative definitions within parts 155 and 156.

**IV. Provisions of the Final Regulations**

For the most part, this final rule incorporates the provisions of the proposed rule. Those provisions of this final rule that differ from the proposed rule are as follows:

Changes to §155.20

- Changes full definitions to statutory and regulatory definitions, where applicable, including the definitions of "applicant," "eligible employer-sponsored plan," "health plan," "plain language," "individual market," and "small group market."
- Added definitions for "application filer," "educated health care consumer," and "Exchange Blueprint."

Changes to §155.105

- Adds that HHS would consult with other relevant Federal agencies in approval of State Exchanges.
- Establishes timeframe for review of significant changes to one where any change would receive written approved or denial within 60 days, or the approval would be automatic after 60 days (which may be extended by 30 days by HHS).

Changes to §155.110

- Establishes that other State agencies are eligible contracting entities (such as departments of insurance).
- Establishes that Exchange boards must have at least one consumer representative on a governing board.

Changes to §155.160

- Streamlines language regarding user fees, and removed policy that States announce user fees annually.

Changes to §155.200

- Removes appeals of eligibility determinations as a minimum Exchange function.
- Adds a clarification that in carrying out its statutorily-required responsibilities, the Exchange is not construed to be acting on behalf of a QHP to convey that Exchanges are not automatically considered HIPAA business associates.

Changes to §155.205

- Adds more detail regarding meaningful access standards.
- Clarifies standards for persons with disabilities, including the provision of auxiliary aids at no cost to the individual.

- Outlines standards for limited English proficient individuals, including oral and written translations and the use of taglines on the Exchange Web site.

Changes to §155.210

- Directs Exchanges to develop and publicly disseminate conflict of interest standards and training standards for entities to be awarded Navigator grants.
- Applies privacy and security standards to Navigators.
- Establishes that at least one Navigator entity must be a community and consumer-focused non-profit group.
- Clarifies entities that are not eligible to serve as Navigators.
- Prohibits Navigators from receiving compensation by issuers for enrollment into plans outside of the Exchange.

Changes to §155.220

- Establishes standards related to the ability of a State to permit agents and brokers to assist qualified individuals enrolling in QHPs through an Exchange; as described elsewhere in this rule, this provision is being published as interim.
- Establishes participation standards for agents and brokers to facilitate QHP selection through a non-Exchange website.

Changes to §155.230

- Aligns notices with expanded meaningful access standards in §155.205.
- Maintains standard that the Exchange must re-evaluate the appropriateness and usability of applications, forms, and notices, but removes the policy that this must occur "on an annual basis and in consultation with HHS in instances when significant changes are made."
- Adds that a notice must include a reason for intended action.

Changes to §155.240

- Removes duplicative standard for the Exchange to accept aggregated payments from qualified employers; §155.705(b)(4) retains the premium aggregation function for the SHOP.

Changes to §155.260

- Removed definition of "personally identifiable information."
- Includes more specific standards for privacy and security of personally identifiable information.
- Includes privacy and security principles based on the Fair Information Practice Principles (FIPPs) framework adopted by ONCHIT and a list of critical security outcomes.
- Clarifies that the privacy and security standards of this section apply only to information created or collected for the purposes of carrying out Exchange minimum functions.
- Expands the scope of information to which the standards apply to information created, collected, used, or disclosed by an Exchange or other individual or entity that has an agreement with the Exchange
- Adds the standard that the Exchange workforce complies with the privacy and security policies and procedures developed and implemented by the Exchange.
- Establishes that Exchanges must develop and utilize secure electronic interfaces when sharing personally identifiable information electronically.
- Adds standards for data matching and sharing arrangements that facilitate the sharing of personally identifiable information between the Exchange and agencies administering Medicaid, CHIP or the BHP.

Changes to §155.300

- Adds that 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 §155.435(a), and as described elsewhere in this rule, this provision is being published as interim final.

Adds §155.302

- Adds section outlining options for (1) the Exchange to conduct assessments of eligibility for Medicaid and CHIP rather than an eligibility determination for Medicaid and CHIP, and; (2) the Exchange to implement a determination of eligibility for advance payments of the premium tax credit and cost-sharing reductions for the Exchange, and as described elsewhere in this rule, this provision is being published as interim.
- Includes standards for such assessments and eligibility determinations, and as described elsewhere in this rule, this provision is being published as interim.

Changes to §155.305

- Adds language throughout to clarify that individuals must be "living" in the service area of the Exchange in addition to the prior standards for residency, in order to align with changes to Medicaid residency standards.
- Adds that an applicant age 21 and over also meets the residency standard if he or she has entered the service area of the Exchange with a job commitment or seeking employment (whether or not currently employed), in order to align with changes to Medicaid residency standards.
- Adds language clarifying how to address cost-sharing reductions in situations in which multiple tax households are covered by a single policy, and as described elsewhere in this rule, this provision is being published as interim.

- Clarifies that cost-sharing reductions use the same household income and FPL definitions as advance payments of the premium tax credit.

Changes to §155.310

- Adds language directing Exchanges to obtain attestations from a tax filer regarding advance payments of the premium tax credit, with flexibility to identify specific attestations in future guidance.
- Adds language clarifying that applicants must provide social security numbers.
- Adds a standard that the Exchange must determine eligibility promptly and without undue delay, and as described elsewhere in this rule, this provision is being published as interim.
- Adds content, consistent with the statute, to the notice to an employer regarding an employee's eligibility for the advanced payment of tax credits.
- Adds the standard to provide employer with an indication the employee has been determined eligible for advance payments of the premium tax credit, that the employer may be liable for the payment assessed under section 4980H of the Code if they have more than 50 full-time employees, and that the employer has the right to appeal the determination.

Changes to §155.315

- Provides flexibility for the Exchange to accept attestation of residency or examine electronic data sources, regardless of the choices made by the State Medicaid or CHIP agencies.
- Adds provision specifying that the Exchange will validate all social security numbers with SSA.
- Allows applicants and application filers to submit documentation to resolve inconsistencies via channels available for submission of application.
- Includes a new provision which specifies that the Exchange will accept an applicant's

attestation if documentation with which to resolve an inconsistency does not exist or is not reasonably available, with the exception of inconsistencies related to citizenship and immigration status, and as described elsewhere in this rule, this provision is being published as interim.

Changes to §155.320

- Sets forth that if an applicant's attestation to projected annual household income is no more than ten percent below his or her prior tax data, the Exchange must rely on the attestation without further verification as part of the alternate verification process, and specifies that if his or her attestation is greater than ten percent below his or her prior tax data, the Exchange will conduct further verification.
- Allows the use of the alternate income verification process when a tax filer's filing status has changed, as directed by statute.
- Allows the use of the alternate income verification process when a tax filer's family composition has changed or is reasonably expected to change.
- Clarifies that if there is no tax data, the Exchange must discontinue advance payments of the premium tax credit and cost-sharing reductions at the end of the 90 day inconsistency period.
- Clarifies that the Exchange verify whether an applicant reasonably expects to be enrolled in employer-sponsored insurance the year for which he or she is seeking coverage, in addition to whether the applicant is currently enrolled.

Changes to §155.330

- Allows the Exchange to establish a reasonable threshold for changes in income that an enrollee must report.
- Allows the Exchange to expand data matching during the benefit year within certain

standards and without HHS approval.

- Adds procedures for notifying and redetermining an enrollee's eligibility upon obtaining data via data matches; outlines different procedures for data related to income, family size, or family composition and data not related to income, family size, or family composition.
- Allows the Exchange to align eligibility effective dates for redeterminations with coverage effective dates in Subpart E.

Changes to §155.335

- Adds timing standard for annual redetermination notice and provides that the annual redetermination notice be combined with the annual notice of open enrollment into a single, coordinated notice in the first two years.
- Provides flexibility to States on timing of notice starting with redeterminations of coverage effective on or after January 1, 2017, and sets forth standards for such flexibility.
- Clarifies effective dates of annual redetermination.
- Adds that the Exchange is authorized to obtain tax data for a period of up to five years, unless the individual declines this authorization or chooses to authorize for a period of less than five years.
- Adds limitation to redetermination if an individual requests eligibility determination for insurance affordability programs but does not have an authorization for the Exchange to obtain tax data as part of annual redetermination process; Exchange must notify enrollee and not proceed with redetermination until authorization has been obtained or enrollee declines financial assistance.

Changes to §155.340

- Replaces "Social Security number" with "taxpayer identification number," in accordance

with statute.

- Adds the standard that the Exchange must transmit promptly and without undue delay information to enable advance payments of the premium tax credits and cost-sharing reductions, and as described elsewhere in this rule, this provision is being published as interim.

Changes to § 155.345

- Adds standards for agreements between the Exchange and other insurance affordability programs, and as described elsewhere in this rule, this provision is being published as interim.
- Clarifies responsibilities of the Exchange when applicants are found potentially eligible for Medicaid based on factors other than MAGI which includes notifying the applicant; clarifies standards for providing advance payments of the premium tax credit and cost-sharing reductions to such individuals.
- Adds standards for the Exchange when accepting applications from other insurance affordability programs and sending applications to agencies administering other insurance affordability programs, and as described elsewhere in this rule, this provision is being published as interim.
- Adds a special rule providing that if the Exchange finds a tax filer's household income is less than 100 percent of the FPL and one or more applicant in the tax filer's household is found ineligible for Medicaid or CHIP, the Exchange follow the procedures in §155.320(c)(3).

Changes to §155.350

- Clarifies that an individual must be eligible for advance payments of the premium tax credit in order to be eligible for cost-sharing reductions, in accordance with statute.

- Clarifies that cost-sharing reductions use the same household income and FPL definitions as advance payments of the premium tax credit.

Changes to §155.400

- Adds policy in §155.400(b)(2) for Exchanges to submit eligibility and enrollment information to HHS and QHP issuers promptly and without undue delay.
- Removes policy from §155.400(c) that the Exchange must submit enrollment information to HHS on a monthly basis.
- Adds policy in §155.400(d) that the Exchange must reconcile enrollment information with HHS and QHP issuers on a monthly basis.

Changes to §155.410

- Extends the initial open enrollment period from February 28, 2014 to March 31, 2014.
- Modifies the standards in this section such that an enrollment transaction must be received by the 15th of the month to secure an effective date of the first of the following month.
- Gives the Exchange flexibility to negotiate earlier effective dates and/or later plan selection cutoff dates, but notes that the Exchange must secure agreement from all participating QHP issuers. Further, an earlier effective date can only be offered to an individual who is not determined eligible for or forgoes advance payments of the premium tax credit/cost-sharing reductions for the first partial month of coverage.
- Gives the Exchange the option to automatically enroll individuals contingent upon demonstrating good cause to HHS.

Changes to §155.420

- Aligns coverage effective dates for special enrollment periods with the new dates for the initial open enrollment periods as described in §155.410, except in the case of marriage or

loss of minimum essential coverage.

- Removes the limits on special enrollment periods formerly in §155.420(f).

Changes to §155.430

- Defines reasonable notice, for the purposes of effectuating a termination, as 14 days.
- Clarifies the effective dates of terminations for enrollees under various scenarios, including individuals newly eligible for Medicaid, CHIP, or CHIP; and individuals receiving advance payments of the premium tax credit.

Changes to §155.700

- Adds a definition for minimum participation rules.

Changes to §155.705

- Permits the SHOP to impose minimum participation rules at the SHOP level.
- Adds a standard that the SHOP develop and offer a premium calculator.

Changes to §155.715

- Clarifies that SHOPs may not use section 1411(b)(2) or 1411(c) verification processes for the SHOP eligibility determination process.
- Clarifies that for eligibility determination purposes, the SHOP may collect only the minimum information necessary to make such a determination.

Changes to §155.720

- Adds a standard that the SHOP must report to the IRS employer participation and employee enrollment information in a form and manner specified by HHS.

Changes to §155.725

- Adds a standard that the SHOP offer the same special enrollment periods as the individual Exchange, with the exception of changes in citizenship status or eligibility for insurance

affordability programs.

- Clarifies that the annual election/open enrollment periods for employers/employees must be at least 30 days.
- Clarifies that the SHOP provide newly qualified employees with a specified enrollment period.

Changes to §155.730

- Adds safeguards to protect information collected on application.

Changes to §155.1010

- Clarifies that multi-State plans and CO-OPs are recognized as QHPs.
- Allows Exchanges to certify QHPs during the plan/benefit year if necessary.

Changes to §155.1020

- Clarifies that multi-State plans are exempt from the Exchange process for receiving and considering rate increase justifications, and from the Exchange process for receiving annual rate and benefit information.
- Establishes that the Exchange must post rate increase justifications on its Web site.

Changes to §155.1040

- Clarifies that multi-State plans must submit transparency data in a time and manner determined by the U.S. Office of Personnel Management.

Changes to §155.1045

- Clarifies that the U.S. Office of Personnel Management will establish the accreditation timeline for multi-State plans.

Changes to §155.1050

- Clarifies that the U.S. Office of Personnel Management will ensure compliance with

network adequacy standards by multi-State plans.

- Clarifies that a QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider designated under §156.235(c).

Changes to §155.1065

- Clarifies that stand-alone dental plans must meet most QHP certification standards, including §155.1020(c) and that stand-alone dental plans must offer the pediatric dental essential health benefit without annual and lifetime limits as applied to the essential health benefits in section 1302(b) of the Affordable Care Act.
- Adds a standard for the Exchange to ensure sufficient access to pediatric dental coverage.

Changes to §155.1075

- Exempts multi-State plans and CO-OPs from the Exchange recertification process.

Changes to §155.1080

- Exempts multi-State plans and CO-OPs from the Exchange decertification process.

Changes to §156.50

- Clarifies that participating issuers must remit user fees, as defined by an Exchange, and other assessments, if applicable, to a State-based or Federally-facilitated Exchange.

Changes to §156.225

- Codifies the statutory prohibition against QHP benefit designs that have the effect of discouraging enrollment by higher-need individuals.

Changes to §156.230

- Expands the proposed standard such that a QHP must maintain a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse, to assure that all services will be accessible without unreasonable delay.

Changes to §156.235

- Sets minimum standards that a QHP must have a sufficient number and geographic distribution of essential community providers to ensure reasonable and timely access to a broad range such providers for low-income, medically underserved individuals in the QHP's service area.
- Clarifies the definition of essential community provider to include providers that met the criteria to be an essential community provider on the publication date of this regulation unless the provider lost its status as an essential community provider as a result of violating Federal law.
- Establishes an alternate standard for integrated delivery systems and staff model plans.
- Clarifies payment policy with respect to FQHCs and all other essential community providers.

Changes to §156.255

- Removes provision related to covering specific rating categories or groups.

Changes to §156.265

- Clarifies the role of the QHP issuer in the enrollment process for enrollment through the Exchange.

Changes to §156.270

- Adds a standard that the QHP issuer must notify the affected individual 30 days in advance of a termination.
- Clarifies that for individuals receiving advance payments of the premium tax credit who are terminated for non-payment, the QHP issuer must pay all claims for the first month of the grace period. The issuer may pend claims during the second and third months, but must notify providers. Finally, the issuer must return to Treasury any advance payment of the

premium tax credit for the second and third months at the conclusion of the grace period and effectuate termination of coverage at the end of the first month of the grace period.

Changes to §156.280

- Codifies the pre-regulatory model guidelines on issuer segregation plans.

Changes to §156.285

- Clarifies that QHP issuers must provide newly qualified employees with a specified enrollment period.
- Clarifies that QHP issuers participating in the SHOP may not set minimum participation rules for offering health coverage in connection with a QHP.

Changes to §156.295

- Modifies definition of "bona fide service fees."

Changes to §157.205

- Removes requirement for SHOP to continue coverage if employer fails to take action during election period.

**V. Collection of Information Requirements**

**Paperwork Reduction Act**

As noted above, this final rule incorporates provisions originally published as two proposed rules, the July 15, 2011 rule titled Establishment of Exchanges and Qualified Health Plans, and the August 17, 2011 rule titled Exchange Functions in the Individual Market: Eligibility Determinations and Exchange Standards for Employers. These proposed rules are referred to collectively as the Exchange establishment and eligibility proposed rules. In the Exchange establishment proposed rule published on July 15, 2011, we sought comment on certain information collection requirements associated with that proposed rule. We received one

comment that stated a concern regarding the adequacy of the burden estimates stated in the Collection of Information Requirements section. We considered the commenter's concern and plan to issue more detail regarding the collection of information requirements in this rule.

In the Exchange establishment proposed rule, we explained that we would seek comments on the standards associated with §155.105, which are finalized in this rule as the standards for the Exchange Blueprint. On November 10, 2011, we issued a 60-day Federal Register Notice seeking comments on a template for the Exchange Blueprint. For more information, please see page 70418 of Vol. 76, No. 218 of the Federal Register.

In the Exchange eligibility proposed rule published on August 17, 2011, we did not seek comment on the associated information collection requirements. In accordance with the Paperwork Reduction Act (PRA), we will issue a Federal Register Notice in the coming weeks to seek public comments on these provisions.

In addition, this final rule includes certain regulatory provisions that differ from those included in the Exchange establishment proposed rule. Some of those provisions involve changes from the information collection requirements described in the Exchange establishment proposed rule. These changes include the following:

- Exchange up-to-date Internet website (§155.205);
- Standard for Exchanges to maintain records of enrollment (§155.400);
- Standard for Exchanges to submit eligibility and enrollment information to QHP issuers and HHS promptly and without undue delay and reconcile enrollment information with QHP issuers and HHS on at least a monthly basis (§155.400);
- Notice of eligibility to applicant (§155.405);
- Notice of annual open enrollment period to applicant (§155.410);

- Standard for Exchanges to maintain records of coverage terminations (§155.430);
- Notice to employers (§155.715);
- Notice to individual of inability to substantiate employee status (§155.715);
- Notice of employer eligibility (§155.715);
- Notice of employee eligibility (§155.715);
- Notice of employer withdrawal from SHOP (§155.715);
- Notice of effective date to employees (§155.720);
- Notice of employee termination of coverage to employer (§155.720);
- Standard for the SHOP to maintain records of enrollment (§155.720);
- Standard for the SHOP to reconcile enrollment information (§155.720);
- Notice of annual employer election period (§155.725);
- Notice to employee of open enrollment period (§155.725);
- Standard for Exchanges to collect QHP issuer reports on covered benefits, rates, and cost sharing requirements (§155.1020);
- Notice to the QHP issuer, enrollees, HHS, and the State insurance department of the decertification of a QHP (§155.1080);
- Issuer reporting of benefit and rate information (§156.210);
- Issuer reporting of rate increase justifications (§156.210);
- Issuer reporting of transparency in coverage information (§156.220);
- Standard for QHP issuers to make available enrollee cost sharing information (§156.220);
- Notice to applicants and enrollees that includes the provider directory (§156.230);
- Notice of effective date of coverage to individuals (§156.260);
- Standard for QHP issuers to collect enrollment information and submit the enrollment

information to the Exchange (§156.265);

- Standard for QHP issuers to provide an enrollment package to enrollee (§156.265);
- Summary of cost and coverage document(§156.265);
- Standard for QHP issuers to reconcile enrollment information with the Exchange (§156.265);
- Notice to the enrollee of the termination of coverage (§156.270);
- Notice to the enrollee of payment delinquency (§156.270);
- Standard for QHP issuers to maintain records of coverage terminations (§156.270);
- Standard for QHP issuers to provide enrollment information package to SHOP enrollees (§156.285);
- Summary of cost and coverage document for employees and employers (§156.285);
- Standard for QHP issuers to reconcile enrollment information with the SHOP (§156.285);
- Notice to SHOP enrollee of the termination of coverage (§156.285);
- Notice of QHP issuer non-renewal of certification to Exchange (§156.290);
- Notice of QHP issuer non-renewal of certification to enrollees (§156.290); and
- Standard for QHP issuers to submit prescription drug distribution and cost reporting (§156.295);

This final rule also includes some information collection requirements for which we did not seek comment in the Exchange establishment proposed rule. In accordance with the Paperwork Reduction Act (PRA), we will issue a Federal Register Notice in the coming weeks to seek public comments on these provisions.

Finally, this final rule describes some information collections for which CMS plans to seek approval at a later date. For these information collections, CMS will issue future Federal

Register notices to seek comments on those information collections, as required by the PRA. This includes, among other collections:

- Navigator standards (§155.210);
- Single streamlined application to determine eligibility and collect information for enrollment (§155.405);
- SHOP single employer application (§155.715);
- SHOP single employee application (§155.715);
- Alternative employer application (§155.730);
- Collection of rates, covered benefits, and cost sharing information (§155.200);
- Collection of transparency of coverage information (§155.1040);
- Evaluation of service area (§155.1055);
- Standards for the certification of stand-alone dental plans (§155.1065);
- Submission of rates, covered benefits, and cost sharing information (§156.210); and
- Submission of transparency of coverage information (§156.220).

**VI. Summary of Regulatory Impact Analysis**

The summary analysis of benefits and costs included in this rule is drawn from the detailed Regulatory Impact Analysis. That impact analysis evaluates the impacts of this rule and a second rule, "Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment." The second final rule will be published separately. The following summary focuses on the benefits and costs of this final rule.

A. Introduction

HHS has examined the impacts of this final rule under Executive Orders 12866 and 13563, the Regulatory Flexibility Act (5 U.S.C. 601-612), the Unfunded

Mandates Reform Act of 1995 (Public Law 104-4), and the Executive Order 13132 on Federalism. Executive Orders 13563 and 12866 direct agencies to assess all costs and benefits (both quantitative and qualitative) of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). Executive Order 13563 emphasizes the importance of quantifying both costs and benefits, of reducing costs, of harmonizing rules, and of promoting flexibility. This rule has been designated an "economically" significant rule, under section 3(f)(1) of Executive Order 12866. Accordingly, the rule has been reviewed by the Office of Management and Budget.

The Regulatory Flexibility Act requires agencies to analyze regulatory options that would minimize any significant impact of a rule on small entities. Using the Small Business Administration (SBA) definitions of small entities for issuers, agents and brokers, and employers, HHS concludes that a significant number of firms affected by this final rule are not small businesses.

Section 202(a) of the Unfunded Mandates Reform Act of 1995 requires that agencies prepare a written statement, which includes an assessment of anticipated costs and benefits, before promulgating "any rule that includes any Federal mandate that may result in the expenditure by State, local, and tribal governments, in the aggregate, or by the private sector, of $100,000,000 or more (adjusted annually for inflation) in any one year." The current threshold after adjustment for inflation is approximately $136 million, using the most current (2011) Implicit Price Deflator for the Gross Domestic Product. HHS does not expect this final rule to result in one-year expenditures that would meet or exceed this amount.

Executive Order 13132 establishes certain requirements that an agency must meet when it

promulgates a final rule that imposes substantial direct costs on State and local governments, preempts State law, or otherwise has Federalism implications. Specifically, an agency must act in strict accordance with the governing law, consult with State officials, and address their concerns.

B. Need for This Regulation

This final rule implements standards related to the Establishment of Exchanges and Qualified Health Plans and standards for Qualified Employers consistent with the Affordable Care Act. The Exchanges will provide competitive marketplaces for individuals and small employers to directly compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges, which will become operational by January 1, 2014, will help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small business the same purchasing power as large businesses.

C. Summary of Costs and Benefits of the Regulation

This summary focuses on the benefits and costs of the requirements in this Exchange final rule that combines the policies in the Exchange establishment proposed rule and the Exchange eligibility proposed rule.

Benefits in response to the regulation**:**

The Exchanges and their associated policies, according to CBO's letter to Evan Bayh from November 30, 2009, reduce premiums for the same benefits compared to prior law. CBO estimated that, in 2016, people purchasing non-group coverage through the Exchanges would pay 7 to 10 percent less due to the healthier risk pool that results from the coverage expansion. An additional 7 to 10 percent in savings would result from gains in economies of scale in purchasing insurance and lower administrative costs from elimination of underwriting, decreased marketing costs, and the Exchanges' simpler system for finding and enrolling individuals in

health insurance plans.[17]

CBO also estimates that premiums for small businesses purchasing through the Exchanges would be to 2 percent lower than they would be without the Affordable Care Act, for comparable reasons. CBO estimated that the administrative costs to health plans (described in greater detail below) would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, and end underwriting. Premium savings to individuals and small businesses allow for alternative uses of income and resources, such as increasing retirement savings for families or investing in new jobs for small businesses.

Simplified eligibility processes will increase take-up of health insurance leading to improved health. In a recent study, compared to the uninsured group, the insured received more hospital care, more outpatient care, had lower medical debt, better self-reported health, and other health related benefits. The evaluation concluded that for low-income uninsured adults, coverage has the following benefits: (1) significantly higher utilization of preventive care (mammograms, cholesterol monitoring, blood tests for high blood sugar related to diabetes, etc.); (2) a significant increase in the probability of having a regular office or clinic for primary care; and, (3) significantly better self-reported health. In addition, the use of electronic records among State and Federal agencies with information to verify eligibility will minimize the transaction costs associated with purchasing health insurance improving market efficiency and minimizing time cost for enrollees on enrollment.

Costs in response to the regulation

Meeting the requirements of this rule will have costs affecting Exchanges and issuers of qualified health plans (QHPs). The administrative costs of operating an Exchange will almost

[17] Congressional Budget Office, "Letter to the Honorable Evan Bayh: An Analysis of Health Insurance Premiums Under the Patient Protection and Affordable Care Act " (Washington2009).

certainly vary by the number of enrollees in the Exchange due to economies of scale, variation in the scope of the Exchange's activities, and variation in average premium in the Exchange service areas. However, we believe major cost components for Exchanges will include: IT infrastructure, Navigators, notifications, enrollment standards, application process, SHOP, certification of QHPs, and quality reporting. The major costs on issuers of QHPs will include: accreditation, network adequacy standards, and quality improvement strategy reporting. CBO estimates that the administrative costs to QHP issuers would be more than offset by savings resulting from lower overhead due to new policies to limit benefit variation, prohibit "riders," and end under-writing.

To support the new eligibility structure, States are expected to build new or modify existing information technology systems. How each State constructs and assembles the components necessary to support its Exchange and Medicaid infrastructure will vary and depend on the level of maturity of current systems, current governance and business models, size, and other factors. Administrative costs to support the vision for a streamlined and coordinated eligibility and enrollment process will also vary for each State depending on the specific approaches taken regarding the integration between programs and its decision to build a new system or use existing systems; while the Affordable Care Act requires a high level of integration, States have the option to go beyond the requirements of the Act.

We also believe that overall administrative costs may increase in the short term as States build information technology systems; however, in the long-term States will see savings through the use of more efficient systems. As noted in the preamble, we believe the approach we are taking to supporting the verification of applicant information with SSA, IRS, and DHS reduces administrative complexity and associated costs. Administrative costs to States incurred in the

development of information technology infrastructure to support the Exchange are funded wholly through State Exchange Planning and Establishment Grants. Costs for information technology infrastructure that will also support Medicaid must be allocated to Medicaid, but are eligible for a time-limited 90 percent Federal matching rate to assist in development.

Methods of analysis

This impact analysis references both estimates from the Congressional Budget Office (CBO), as well as Center for Medicare & Medicaid Services (CMS) estimates from the FY 2013 President's Budget. The CBO estimate remains the most comprehensive accounting of all the interacting provisions pertaining to the Affordable Care Act, and contains cost estimates of some provisions that have not been independently estimated by CMS. Based on our review, we expect that the requirements in these final rules will not significantly alter CBO's estimates of the budget impact of Exchanges or enrollment. The requirements are well within the parameters used in the modeling of the Affordable Care Act. Our review and analysis of the requirements indicate that the impacts are within the model's margin of error. In the regulatory impact analysis that accompanied the proposed Exchange establishment rule, we displayed CBO estimates of Exchange grant outlays. The estimates in this analysis reflect the most up-to-date estimates from the FY 2013 President's Budget for State Planning and Establishment Grants.

Table 1 includes the estimates of grants to States for Exchange start up from 2012 to 2016. It does not include costs related to reduced Federal revenues from refundable premium tax credits, which are administered by the Department of the Treasury subject to IRS rulemaking, the Medicaid effects, which are subject to separate rulemaking, or the policies whose offsets led CBO to estimate that the Affordable Care Act would reduce the Federal budget deficit by over $100 billion over the next 10 years. As this is a summary of the final impact analysis, for further

information on the expected benefits and costs of this rule, please see the final regulatory impact analysis.

**Table 1. Estimated Outlays for the Affordable Insurance Exchanges FY 2012 - FY2016, in billions of dollars**

| Year | 2012 | 2013 | 2014 | 2015 | 2016 | 2012-2016 |
|---|---|---|---|---|---|---|
| Grant Authority for Exchange Start up[a] | 0.9 | 1.1 | 0.8 | 0.4 | 0.1 | 3.4 |

[a] FY 2013 President's Budget, *Analytical Perspectives*, Table 32-1

Regulatory Options Considered

In addition to a baseline, HHS has identified three regulatory options for this final rule as required by Executive Order 12866 for Exchange establishment and eligibility.

(1) Uniform Standard for Operations of an Exchange.

Under this alternative HHS would require a single standard for State operations of Exchanges. The regulation offers States the choice of whether to establish an Exchange, how to structure governance of the Exchange, whether to join with other States to form a regional Exchange, and how much education and outreach to engage in, among other factors. This alternative model would restrict State flexibility, requiring a more uniform standard that States must enact in order to achieve approval of an Exchange.

(2) Uniform Standard for Health Insurance Coverage

Under this alternative, there would be a single uniform standard for certifying QHPs. QHPs would need to meet a single standard in terms of benefit packages, network adequacy, premiums, etc. HHS would set these standards in advance of the certification process and QHPs would

either meet those standards and thereby be certified or would fail to meet those standards and therefore would not be available to enrollees.

(3) Require a Paper-Driven Process for Conducting Eligibility Determinations

In this final rule, to verify applicant information used to support an eligibility determination, we generally require the Exchange first use electronic data, where available, prior to requesting paper documentation. Under this rule, individuals will be asked to provide only the minimum amount of information necessary to complete an eligibility determination, and will only be required to submit paper if electronic data cannot be used to complete the verification process. Under this alternative, the Exchange would require individuals to submit paper documentation to verify information necessary for an eligibility determination. This would not only increase the amount of burden placed on individuals to identify and collect this information, which may not be readily available to the applicant, but would also necessitate additional time and resources for Exchanges to accept and verify the paper documentation needed for an eligibility determination.

Summary of costs for each option

HHS notes that Option 1, which promotes uniformity, could produce a benefit of reduced Federal oversight cost; however this option would reduce innovation and therefore limit diffusion of successful policies and furthermore interfere with Exchange functions and needs. HHS also notes that while Option 2 could produce administrative burdens on Exchanges, this approach could reduce Exchanges' and QHP issuers' ability to innovate. These costs and benefits are discussed more fully in the detailed Regulatory Impact Analysis.

The paper-driven process in option 3 would ultimately increase the amount of time it would take for an individual to receive health coverage, would reduce the number of States likely to operate an Exchange due to increased administrative costs, and would dissuade individuals

from seeking coverage through the Exchange. We believe using technology to minimize burden on individuals and States will help increase access to coverage by streamlining the eligibility process, and will reduce administrative burden on Exchanges, while increasing accuracy by relying on trusted data for eligibility.

VIII. Accounting Statement

| | Estimates | | | Units | | |
|---|---|---|---|---|---|---|
| **Category** | **Primary Estimate** | **Low Estimate** | **High Estimate** | **Year Dollar** | **Discount Rate** | **Period Covered** |
| **Benefits** | | | | | | |
| Annualized Monetized ($millions/year) | Not Estimated | $ - | $ - | 2011 | 7% | 2012-2016 |
| | Not Estimated | $ - | $ - | 2011 | 3% | 2012-2016 |
| Qualitative | The Exchanges, combined with other actions being taken to implement the Affordable Care Act, will improve access to health insurance, with numerous positive effects, including earlier treatment and improved morbidity, fewer bankruptcies and decreased use of uncompensated care. The Exchange will also serve as a distribution channel for insurance reducing administrative costs as a part of premiums and providing comparable information on health plans to allow for a more efficient shopping experience. | | | | | |
| **Costs** | | | | | | |
| Annualized Monetized ($millions/year) | $ 690.55 | Not Estimated | Not Estimated | 2011 | 7% | 2012-2016 |
| | $ 673.50 | Not Estimated | Not Estimated | 2011 | 3% | 2012-2016 |
| Qualitative | These costs include grant outlays to States to establish Exchanges | | | | | |
| **Transfers** | | | | | | |
| Federal Annualized Monetized ($millions/year) | 0 | $ - | $ - | 2011 | 7% | 2012-2016 |
| | 0 | $0.00 | $0.00 | 2011 | 3% | 2012-2016 |
| From/To | From: | | | To: | | |
| Other Annualized Monetized ($millions/year) | 0.0 | 0.0 | 0.0 | | | |
| | 0.0 | 0.0 | 0.0 | | | |
| From/To | From: | | | To: | | |

**VII. Regulatory Flexibility Act**

The Regulatory Flexibility Act (5 U.S.C. 601 et seq.) (RFA) requires agencies to prepare an regulatory flexibility analysis to describe the impact of the final rule on small entities, unless the head of the agency can certify that the rule will not have a significant economic impact on a substantial number of small entities. The Act generally defines a "small entity" as (1) a proprietary firm meeting the size standards of the Small Business Administration (SBA), (2) a not-for-profit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000. States and individuals are not included in the definition of "small entity." HHS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 to 5 percent.

As discussed above, this final rule is necessary to implement standards related to the Establishment of Exchanges and Qualified Health Plans as authorized by the Affordable Care Act. For purpose of the Regulatory Flexibility Analysis, we expect the following types of entities to be affected by this final rule: (1) QHP issuers; (2) agents and brokers; (3) employers. We believe that health insurers and agents and brokers would be classified under the North American Industry Classification System (NAICS) Codes 524114 (Direct Health and Medical Insurance Carriers) and 524210 (Insurance Agencies and Brokers). According to SBA size standards, entities with average annual receipts of $7 million or less would be considered small entities for both of these NAICS codes. Health issuers could possibly be classified in 621491 (HMO Medical Centers) and, if this is the case, the SBA size standard would be $10 million or less.

As discussed in the Web Portal interim final rule (75 FR 24481), HHS examined the health insurance industry in depth in the Regulatory Impact Analysis we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3,

2004). In that analysis we determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for "small" business established by the SBA (currently $7 million in annual receipts for health insurers, based on North American Industry Classification System Code 524114)[18].

Additionally, as discussed in the Medical Loss Ratio interim final rule (75 FR 74918), the Department used a data set created from 2009 National Association of Insurance Commissioners (NAIC) Health and Life Blank annual financial statement data to develop an updated estimate of the number of small entities that offer comprehensive major medical coverage in the individual and group markets. For purposes of that analysis, the Department used total Accident and Health (A&H) earned premiums as a proxy for annual receipts. The Department estimated that there were 28 small entities with less than $7 million in accident and health earned premiums offering individual or group comprehensive major medical coverage; however, this estimate may overstate the actual number of small health insurance issuers offering such coverage, since it does not include receipts from these companies' other lines of business.

This rule finalizes Exchange standards related to offering the QHPs. These standards and the associated certification process will impose costs on issuers, but these costs will vary depending on a number of factors, including the operating model chosen by the Exchange, their current accreditation status, and the variation between these standards and current practice. Some QHP issuers will be more prepared to meet the standards than others and will incur fewer costs. For example, if data reporting functions required for certification already exist at the QHP issuer, there would be no additional cost. Exchanges also have the flexibility in some cases to

[18] 'Table of Size Standards Matched To North American Industry Classification System Codes,'' effective November 5, 2010, U.S. Small Business Administration, available at http://www.sba.gov.

set requirements. For example, the rule provides discretion for Exchanges in setting network adequacy standards for participating health insurance issuers. The cost to the issuer will depend on whether the Exchange determines that compliance with relevant State law and licensure requirements is sufficient for a QHP issuer to participate in the Exchange or whether they decide to set additional standards in accordance with current provider market characteristics and consumer needs.

The cost of participating in an Exchange is an investment for QHP issuers, with benefits expected to accrue to QHP issuers. The Exchange will function as an important distribution channel for QHPs. QHP issuers currently fund their own sales and marketing efforts. As a centralized outlet to attract and enroll consumers, the Exchanges will supplement and reduce incremental health plan sales and marketing costs with their consumer assistance, education and outreach functions.

We anticipate that the agent and broker industry, which is comprised of large brokerage organizations, small groups, and independent agents, will play a critical role in enrolling qualified individuals in QHPs. We are codifying section 1312(e) of the Affordable Care Act, which gives States the option to permit agents or brokers to assist individuals in enrolling in QHPs through the Exchange. If a State chooses to allow agents and brokers to assist individuals in enrolling in QHPs through the Exchange, we establish standards that would apply for such enrollment. Agents and brokers must meet these standards and any conditions imposed by the State and, as a result, could incur costs. In addition, agents and brokers who become Navigators will also agree to comply with associated requirements and are likely to incur some costs. Because the States and the Exchanges will make these determinations, we cannot provide an estimate of the potential number of small entities that will be affected or the costs associated with

these decisions.

This final rule establishes requirements on employers that choose to participate in a SHOP. As discussed above, the SHOP is limited by statute to employers with at least one but not more than 100 employees. For this reason, we expect that many employers would meet the SBA Standard for Small entities. We do not believe that the regulation imposes requirements on employers offering health insurance through SHOP that are more restrictive than the current requirements on employers offering employer sponsored health insurance. For this reason, we also believe the processes that we have established constitute the minimum amount of requirements necessary to implement statutory mandates and accomplish our policy goals, and that no appropriate regulatory alternatives could be developed to lessen the compliance burden. We also expect that for some employers, risk pooling and economies of scale will reduce the administrative cost of offering coverage through the SHOP and that they will, therefore, benefit from participation.

**VIII. Unfunded Mandates**

Section 202 of the Unfunded Mandates Reform Act of 1995 (UMRA) requires that agencies assess anticipated costs and benefits and take certain other actions before issuing a final rule that includes any Federal mandate that may result in expenditures in any one year by a State, local, or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2011, that threshold is approximately $136 million. Because States are not required to set up an Exchange, and because grants are available for funding of the establishment of an Exchange by a State, we anticipate that this final rule would not impose costs above that $136 million UMRA threshold on State, local, or tribal governments.

**IX. Federalism**

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a final rule that imposes substantial direct costs on State and local governments, pre-empts State law, or otherwise has Federalism implications. Because States have flexibility in designing their Exchange, State decisions will ultimately influence both administrative expenses and overall premiums. States are not required to establish an approved Exchange. For States electing to create an Exchange, much of the initial costs to the creation of Exchanges will be funded by Exchange Planning and Establishment Grants. After this time, Exchanges will be financially self-sustaining with revenue sources at the discretion of the State. Current State Exchanges charge user fees to issuers.

In the Department's view, while this final rule does not impose substantial direct requirement costs on State and local governments, this regulation has Federalism implications due to direct effects on the distribution of power and responsibilities among the State and Federal governments relating to determining standards relating to health insurance coverage (that is, for QHPs) that is offered in the individual and small group markets. Each State electing to establish an Exchange must adopt the Federal standards contained in the Affordable Care Act and in this final rule, or have in effect a State law or regulation that implements these Federal standards. However, the Department anticipates that the Federalism implications (if any) are substantially mitigated because under the statute, States have choices regarding the structure and governance of their Exchanges. Additionally, the Affordable Care Act does not require States to establish an Exchange; if a State elects not to establish an Exchange or the State's Exchange is not approved, HHS, either directly or through agreement with a non-profit entity, must establish and operate an Exchange in that State.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policy making discretion of the States, the Department has engaged in efforts to consult with and work cooperatively with affected States, including participating in conference calls with and attending conferences of the National Association of Insurance Commissioners, and consulting with State insurance officials on an individual basis.

Throughout the process of developing this rule, the Department has attempted to balance the States' interests in regulating health insurance issuers, and Congress' intent to provide access to Affordable Insurance Exchanges for consumers in every State. By doing so, it is the Department's view that we have complied with the requirements of Executive Order 13132.

Pursuant to the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this regulation, the Department certifies that CMS has complied with the requirements of Executive Order 13132 for the attached regulation in a meaningful and timely manner.

**List of Subjects**

45 CFR Part 155

Administrative practice and procedure, Advertising, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Technical assistance, Women, and Youth.

45 CFR Part 156

Administrative practice and procedure, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Grant programs-health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Loan programs-health, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

45 CFR Part 157

Employee benefit plans, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, Indians, Individuals with disabilities, Organization and functions (Government agencies), Medicaid, Public assistance programs, Reporting and recordkeeping requirements, Safety, State and local governments, Sunshine Act, Technical Assistance, Women, and Youth.

For the reasons set forth in the preamble, the Department of Health and Human Services amends 45 CFR subtitle A, subchapter B, as set forth below:

**Subchapter B – Requirements Relating to Health Care Access**

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

1. The authority citation for part 155 is revised to read as follows:

**Authority**: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1334, 1402, 1411, 1412, 1413.

2. Revise the part 155 heading to read as set forth above.

3. Add subparts A through E to read as follows:

**Subpart A – General Provisions**

Sec.



**Subpart B – General Standards Related to the Establishment of an Exchange**

**Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans**



**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 credits specified in section 36B of the Code (as added by section 1401 of the Affordable Care Act) which are provided on an advance basis to an eligible individual enrolled in a QHP through an Exchange in accordance with sections 1402 and 1412 of the Affordable Care Act.

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

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

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 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) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.

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 section 36B(d)(1) of the Code, an authorized representative, or if the applicant is a minor or incapacitated, someone acting responsibly for an applicant.

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

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.

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.

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 qualified

employers. Unless otherwise identified, this term refers to State Exchanges, regional Exchanges, subsidiary Exchanges, and a Federally-facilitated Exchange.

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.

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.

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 101 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 plan years beginning before January 1, 2016, a State may elect to define large employer by substituting ‘‘51 employees’’ for ‘‘101 employees.’’

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 an individual employed by a qualified employer who has been offered health insurance coverage by such qualified employer through the SHOP.

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 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 1 but not more than 100 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 plan years beginning before January 1, 2016, a State may elect to define small employer by substituting ‘‘50 employees’’ for ‘‘100 employees.”

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.

**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 an Exchange that facilitates the purchase of health insurance coverage in QHPs and provides for the establishment of a SHOP.

(b) 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, H, and K of this part;

(2) The Exchange is capable of carrying out the information reporting requirements in accordance with section 36B of the Code;

(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. If a State is not an electing State under §155.100(a) or an electing State does not have an approved or conditionally approved Exchange 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 the case of a Federally-facilitated Exchange, the requirements in §155.130 and subparts C, D, E, H, and K of this part will apply.

**§155.106 Election to operate an Exchange after 2014.**

(a) Election to operate an Exchange after 2014. A State electing to seek approval of its Exchange later than January 1, 2013 must:

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

(2) Have in effect an approved, or conditionally approved, Exchange Blueprint and operational readiness assessment at least 12 months prior to the Exchange's first effective date of coverage; and

(3) Develop a plan jointly with HHS to facilitate the transition from a Federally-facilitated Exchange to a State Exchange.

(b) Transition process for State Exchanges that cease operations. A State that ceases operations of its Exchange after January 1, 2014 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.

**§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. In carrying out the requirements of this part, the State and the Exchange must:

(1) Comply with applicable non-discrimination statutes; and

(2) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

**§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 USC 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) If a State elects to operate its individual market Exchange and SHOP under two governance or administrative structures as described in §155.110(e), the SHOP must encompass a geographic area that matches the geographic area of the regional or subsidiary Exchange.

**§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 non-compliance. Any State described in paragraph (a) of this section must work with HHS to identify areas of non-compliance 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.

**Subpart C – General Functions of an Exchange**

**§155.200 Functions of an Exchange.**

(a) General requirements. The Exchange must perform the minimum functions described in this subpart and in subparts D, E, H, and K 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 related to oversight and financial integrity requirements in accordance with section 1313 of the Affordable Care Act.

(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.

**§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), (c)(2)(i), and (c)(3) of this section.

(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, including at a minimum:

(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.

(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) Oral interpretation;

(ii) Written translations; and

(iii) Taglines in non-English languages indicating the availability of language services.

(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. 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, and must refer consumers to consumer assistance programs in the State when available and appropriate.

(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.

**§155.210 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 expertise in:

(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;

(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 as described in paragraph (c)(2)(i) of this section and an entity from at least one of the other 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;

(2) Be a subsidiary of a health insurance issuer;

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

(4) Receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of any individuals or employees in a QHP or a non-QHP.

(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. 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; and

(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.

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

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

(a) General rule. A State may permit agents and 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) Web site disclosure. The Exchange may elect to provide information regarding licensed agents and brokers on its website for the convenience of consumers seeking insurance through that Exchange.

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

(1) The agent or broker ensures the applicant's completion of an eligibility verification and enrollment application through the Exchange Web site as described in §155.405;

(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) When an Internet website of the agent or broker is used to complete the QHP selection, at a minimum the Internet Web site must:

(i) Meet all standards for disclosure and display of QHP information contained in §155.205(b)(1) and (c);

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

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

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

(v) Maintain audit trails and records in an electronic format for a minimum of ten years; and

(vi) 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.

(d) Agreement. An agent or 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 or broker and the Exchange under which the agent or 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; and

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

(e) Compliance with State law. An agent or 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 and brokers, including applicable State law related to confidentiality and conflicts of interest.

**§155.230 General standards for Exchange notices.**

(a) General requirement. Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers, and enrollees must be written and include:

(1) Contact information for available customer service resources;

(2) An explanation of appeal rights, if applicable; and

(3) A citation to or identification of the specific regulation supporting the action, including the reason for the intended action.

(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 re-evaluate the appropriateness and usability of applications, forms, and notices.

**§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.

**§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 155.20; or determining eligibility for exemptions from the individual 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 to carry out the functions described in §155.200 of this subpart.

(2) The Exchange may not create, collect, use, or disclose personally identifiable information while the Exchange is fulfilling its responsibilities in accordance with §155.200 of this subpart 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 health 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 health 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 health 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 health information;

(v) Collection, use, and disclosure limitations. Personally identifiable health 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 health 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 health 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. Except for tax return information, which is governed by section 6103 of the Code, when collection, use or disclosure is not otherwise required by law, an Exchange must require the same or more stringent privacy and security standards (as §155.260(a)) as a condition of contract or agreement with individuals or entities, such as Navigators, agents, and brokers, that:

(1) Gain access to personally identifiable information submitted to an Exchange; or

(2) Collect, use or disclose personally identifiable information gathered directly from applicants, qualified individuals, or enrollees while that individual or entity is performing the functions outlined in the agreement with the Exchange.

(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 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 USC 552a(a)(8), comply with 5 USC 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 civil penalty of not more than $25,000 per person or entity, per use or disclosure, 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 adopted by the Secretary in 45 CFR parts 160 and 162.

(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.

**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:

Adoption taxpayer identification number has the same meaning as it does in 26 CFR 301.6109-3(a).

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 USC 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 (P. 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 plan meets the requirements with respect to coverage of the total allowed costs of benefits set forth in section 36B(c)(2)(C)(ii) of the Code**.**

Modified Adjusted Gross Income (MAGI) has the same meaning as it does in section 36B(d)(2)(B) of the Code.

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 section 36B(c)(2)(C) of the Code.

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 USC 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 or through contracting arrangements in accordance with §155.110(a); 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 subparagraph (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; 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 adheres to the eligibility determination for Medicaid or CHIP made by the State Medicaid or CHIP 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.

(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 with respect to 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.

(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, as defined in section 36B(d)(2) of the Code, of greater than or equal to 100 percent but not more than 400 percent of the FPL 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, with the exception of coverage in the individual market, in accordance with section 36B(c)(2)(B) and (C) of the Code.

(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 section 36B(d)(2) of the Code, 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 non-citizen who is lawfully present and ineligible for Medicaid by reason of immigration status, in accordance with section 36B(c)(1)(B) of the Code.

(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 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 if HHS notifies the Exchange as part of the process described in §155.320(c)(3) that advance payments of the premium tax credit were made on behalf of the tax filer or either spouse if the tax filer is a married couple for a year 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 his or her spouse did not comply with the requirement to file an income tax return for that year as required by 26 USC 6011, 6012, and implementing regulations and reconcile the advance payments of the premium tax credit 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 section 36B of the Code.

(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 multiple tax households. To the extent that an enrollment in a QHP under a single policy covers individuals who are expected to be in different tax households for the benefit year for which coverage is requested, the Exchange must apply only the first category of cost-sharing reductions listed below for which the Exchange has determined that one of the applicants in the tax households is eligible.

(i) §155.350(b);

(ii) Paragraph (g)(2)(iii) of this section;

(iii) Paragraph (g)(2)(ii) of this section;

(iv) Paragraph (g)(3)(i) of this section;

(v) §155.350(a).

(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.

**§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 USC 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 eligibility for 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 or cost-sharing reductions upon determination that an employee is eligible for advance payments of the premium tax credit or cost-sharing reductions. Such notice must:

(1) Identify the employee;

(2) Indicate that the employee has been determined eligible for advance payments of the premium tax credit;

(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) Duration of eligibility determinations without enrollment. To the extent that an applicant who is determined eligible for enrollment in a QHP does not select a QHP within his or her enrollment period in accordance with subpart E, and seeks a new enrollment period --

(1) Prior to the date on which his or her eligibility would have been redetermined in accordance with §155.335 had he or she enrolled in a QHP, 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 an enrollment period, and must process any changes reported in accordance with the procedures specified in §155.330.

(2) On or after the date on which his or her eligibility would have been redetermined in accordance with §155.335 had he or she enrolled in a QHP, the Exchange must apply the procedures specified in §155.335 before determining his or her eligibility for an enrollment period.

**§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, 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, advance payments of the premium tax credit, and cost-sharing reductions, including when electronic data is required in accordance with this subpart but not available, 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 period described in paragraph (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, must –

(i) 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 (i) 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; and

(ii) Effectuate the determination specified in paragraph (f)(5)(i) of this section no earlier than 10 days after and no later than 30 days after the date on which the notice in paragraph (f)(5)(i) of this section is sent.

(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.

**§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) 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.

(2) 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.

(c) Verification of household income and family/household size. (1) Data. (i) Tax return data. (A) For all individuals whose income is counted in calculating a tax filer's household income, in accordance with section 36B(d)(2) of the Code, or an applicant's household income, in accordance with 42 CFR 435.603(d), and for whom the Exchange has a Social Security number or an adoption taxpayer identification number, the Exchange must request tax return data

regarding MAGI and family size from the Secretary of the Treasury 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, in accordance with section 36B(d)(2) of the Code, or an applicant's household income, 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 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).

(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 tax return 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 increases in household income. (A) 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 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, except as provided in paragraph (c)(3)(iii)(B) of this section.

(B) If 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 available to the Exchange in accordance with paragraph (c)(1)(ii) of this section, 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 using the procedures specified in §155.315(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 and 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 greater than ten percent below the annual household income computed in accordance with paragraph (c)(3)(ii)(A), 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 for the tax filer by --

(A) Using annualized data from the MAGI-based income sources specified in paragraph (c)(1)(ii) of this section;

(B) Using 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; or

(C) If electronic data are unavailable or do not support an applicant's attestation, the Exchange must follow the procedures specified in §155.315(f)(1) through (4).

(D) If, following the 90-day period described in paragraph (c)(3)(vi)(C) 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.

(E) If, at the conclusion of the period specified in paragraph (c)(3)(vi)(C) of this section, 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 paragraph (c)(3)(vi)(C) of this section, 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 this paragraph (c)(3), "household income" means household income as specified in section 36B(d)(2) of the Code.

(viii) For purposes of paragraph (c)(3) of this section, "family size" means family size as specified in section 36B(d)(1) of the Code.

(4) The Exchange must provide education and assistance to an applicant regarding the process specified in this paragraph.

(d) Verification related to enrollment in an eligible employer-sponsored plan. (1) Except as provided in paragraph (d)(2) of this section, the Exchange must verify whether an applicant who requested an eligibility determination for insurance affordability programs is enrolled in an eligible employer-sponsored plan or reasonably expects to be enrolled in an eligible employer-

sponsored plan for the benefit year for which coverage is requested by accepting an applicant's attestation without further verification.

(2) If the Exchange finds that an applicant's attestation regarding enrollment in an eligible employer-sponsored plan is not reasonably compatible with other information provided by the applicant or in the records of the Exchange, 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 may request additional documentation to support the attestation within the procedures specified in §155.315(f).

(e) Verification related to eligibility for qualifying coverage in an eligible employer-sponsored plan. (1) The Exchange must require an applicant to attest to an applicant's eligibility for qualifying coverage in an eligible employer-sponsored plan for the benefit year for which coverage is requested for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions, and to provide information identified in section 1411(b)(4) of the Affordable Care Act.

(2) The Exchange must verify whether an applicant is eligible for qualifying coverage in an eligible employer-sponsored plan for the purposes of eligibility for advance payments of the premium tax credit and cost-sharing reductions.

(f) 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).

(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) 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) Eligibility determinations for Medicare, Medicaid, CHIP, or the BHP, if a BHP 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 paragraphs (e)(2) and (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 not regarding income, family size and family composition. If the Exchange identifies updated information through the data matching taken in accordance with paragraph (d)(1) or through other data matching under paragraph (d)(2) of this section, with the exception of data matching related to income, the Exchange must --

(i) Notify the enrollee regarding the updated information, as well as the enrollee's projected eligibility determination after considering such information;

(ii) Allow an enrollee 30 days from the date of the notice to notify the Exchange that such information is inaccurate; and

(iii) If the enrollee responds contesting the updated information, proceed in accordance with §155.315(f).

(iv) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(ii), proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(3) Data matching regarding income, family size and family composition. If the Exchange identifies updated information regarding income, family size and composition through the data matching taken in accordance with paragraph (c)(2) of this section, the Exchange must –

(i) Follow procedures described in paragraph (e)(2)(i) and (ii) of this section; and

(ii) If the enrollee responds confirming the updated information or providing more up to date information, proceed in accordance with paragraphs (e)(1)(i) and (ii) of this section.

(iii) If the enrollee does not respond within the 30-day period specified in paragraph (e)(2)(ii) of this section, maintain the enrollee's existing eligibility determination without considering the updated information.

(f) Effective dates. (1) Except as specified in paragraphs (f)(2) or (3) of this section, the Exchange must implement changes 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.

(2) The Exchange may determine a reasonable point in a month after which a change captured through a redetermination 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 date described in §155.420(b)(2).

(3) In the case of a redetermination that results in an enrollee being ineligible to continue his or her enrollment in a QHP through the Exchange, the Exchange must maintain his or her eligibility for enrollment in a QHP without advance payments of the premium tax credit and cost-sharing reductions, in accordance with the effective dates described in §155.430(d)(3).

**§155.335 Annual eligibility redetermination.**

(a) General requirement. Except as specified in paragraph (l) of this section, the Exchange must redetermine the eligibility of an enrollee in a QHP through the Exchange on an annual basis.

(b) Updated income and family size information. In the case of an enrollee who requested an eligibility determination for insurance affordability programs in accordance with §155.310(b), the Exchange must request updated tax return information, if the enrollee has authorized the request of such tax return information, and data regarding MAGI-based income as described in §155.320(c)(1) for use in the enrollee's eligibility redetermination.

(c) Notice to enrollee. The Exchange must provide an enrollee with an annual redetermination notice including the following:

(1) The data obtained under paragraph (b) of this section, if applicable; and

(2) The data used in the enrollee's most recent eligibility determination; and

(3) The enrollee's projected eligibility determination for the following year, after considering any updated information described in paragraph (c)(1) 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 enrollees. (1) The Exchange must require an enrollee to report any changes with respect to the information listed in the notice described in paragraph (c) of this section within 30 days from the date of the notice.

(2) 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).

(f) Verification of reported changes. The Exchange must verify any information reported by an enrollee 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 an enrollee, or an application filer, on behalf of the enrollee, to sign and return the notice described in paragraph (c) of this section.

(2) To the extent that an enrollee 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 enrollee's eligibility in accordance with the standards specified in §155.305 using the information provided to the individual in the notice specified in paragraph (c), as supplemented with any information reported by the enrollee and verified by the Exchange in accordance with paragraphs (e) and (f) of this section;

(ii) Notify the enrollee in accordance with the requirements specified in §155.310(g); and

(iii) If applicable, notify the enrollee's employer, in accordance with the requirements specified in §155.310(h).

(2) If an enrollee reports a change with respect to 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 enrollee'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) Renewal of coverage. If an enrollee remains eligible for coverage in a QHP upon annual redetermination, such enrollee will remain in the QHP selected the previous year unless such enrollee terminates coverage from such plan, including termination of coverage in connection with enrollment in a different QHP, in accordance with §155.430.

(k) Authorization of the release of tax data to support annual redetermination. (1) The Exchange must have authorization from an enrollee in order 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 an enrollee 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 notify the enrollee in accordance with the timing described in paragraph (d) of this section. The Exchange may not proceed with the redetermination process described in paragraphs (c) and (e) through (j) of this section until such authorization has been obtained or the enrollee discontinues his or her request for an eligibility determination for insurance affordability programs in accordance with §155.310(b).

**§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 section 36B(c)(2)(C)(i) of the Code, or does not meet the minimum value requirement specified in section 36B(c)(2)(C)(ii) of the Code, 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 specified in section 36B(f)(3) of the Code 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.

**§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 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 program 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 agency administering Medicaid, CHIP, or the BHP, or to the Exchange; and

(3) 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 section 36B(d)(2) of the Code, 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 agencies administering Medicaid, CHIP, or 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) Not duplicate any eligibility and verification findings already made by the transmitting agency, to the extent such findings are made in accordance with this subpart;

(3) Not request information of documentation from the individual already provided to another insurance affordability program and included in the transmission of information provided on the application or other information transmitted from the other program;

(4) 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; and

(5) Provide for following a streamlined process for eligibility determinations regardless of the agency that initially received an application.

(h) 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)(2), 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.

(i) 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 section 36B(d)(2) of the Code, 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.

(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.

**§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) Initial open enrollment period. The initial open enrollment period begins October 1, 2013 and extends through March 31, 2014.

(c) Effective coverage dates for initial open enrollment period. (1) Regular effective dates. For a QHP selection received by the Exchange from a qualified individual –

(i) On or before December 15, 2013, the Exchange must ensure a coverage effective date of January 1, 2014;

(ii) Between the first and fifteenth day of any subsequent month during the initial open enrollment period, the Exchange must ensure a coverage effective date of the first day of the following month; and

(iii) Between the sixteenth and last day of the month for any month between December 2013 and March 31, 2014, the Exchange must ensure a coverage effective date of the first day of the second following month.

(2) Option for earlier effective dates. Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraphs (c)(1)(ii) and (iii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (c)(1)(ii) or (iii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month for any month between December 2013 and March 31, 2014, the Exchange may provide a coverage effective date of the first of the following month.

(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 September 1, and no later than September 30.

(e) Annual open enrollment period. For benefit years beginning on or after January 1, 2015, the annual open enrollment period begins October 15 and extends through December 7 of the preceding calendar year.

(f) Effective date for coverage after the annual open enrollment period. The Exchange must ensure coverage is effective as of the first day of the following benefit year for a qualified individual who has made a QHP selection during the annual open enrollment period.

(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.

**§155.420 Special enrollment periods.**

(a) General requirements. The Exchange must provide special enrollment periods consistent with this section, during which qualified individuals may enroll in QHPs and enrollees may change QHPs.

(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 or placement for adoption, the Exchange must ensure that coverage is effective on the date of birth, adoption, or placement for adoption, but advance payments of the premium tax credit and cost-sharing reductions, if applicable, are not effective until the first day of the following month, unless the birth, adoption, or placement for adoption occurs on the first day of the month; and

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure coverage is effective on the first day of the following month.

(3) Option for earlier effective dates. Subject to the Exchange demonstrating to HHS that all of its participating QHP issuers agree to effectuate coverage in a timeframe shorter than discussed in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may do one or both of the following for all applicable individuals:

(i) For a QHP selection received by the Exchange from a qualified individual in accordance with the dates specified in paragraph (b)(1) or (b)(2)(ii) of this section, the Exchange may provide a coverage effective date for a qualified individual earlier than specified in such paragraphs, provided that either—

(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(c) Length of special enrollment periods. Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(d) Special enrollment periods. The Exchange must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

(1) A qualified individual or dependent loses minimum essential coverage;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee 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) An individual 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, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

(7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

(8) 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; and

(9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(e) Loss of minimum essential coverage. Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801-6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to –

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128.

**§155.430 Termination of coverage.**

(a) General requirements. The Exchange must determine the form and manner in which coverage in a QHP may be terminated.

(b) Termination events. (1) The Exchange must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

(2) The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to terminate such coverage, 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 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted as described in §156.270(g); 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 subtitle;

(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.

(c) Termination of coverage tracking and approval. The Exchange must –

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of coverage;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay, at such time and in such manner as HHS may specify, 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 coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) Effective dates for termination of coverage. (1) For purposes of this section, reasonable notice is defined as fourteen days from the requested effective date of termination.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is –

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(iii) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than fourteen days and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of coverage is the day before such coverage begins.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of coverage is the last day of the month following the month in which the notice described in §155.330(e)(1)(ii) is sent by the Exchange 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 coverage 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 coverage 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.

4. Add subpart H to read as follows:

**Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)**

Sec.

155.730 Application standards for SHOP.

**Subpart H – Exchange Functions: Small Business Health Options Program (SHOP).**

**§155.700 Standards for the establishment of a SHOP.**

(a) General requirement. 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.

(b) Definition. For the purposes of this subpart:

Group participation rule means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

**§155.705 Functions of a SHOP.**

(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, and K 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 §§ 155.710, 155.715, 155.720, 155.725, and 155.730.

(2) Employer choice requirements. With regard to QHPs offered through the SHOP, 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. With regard to QHPs offered through the SHOP, the SHOP may allow a qualified 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.

(4) Premium aggregation. The SHOP must perform the following functions related to premium payment administration:

(i) 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;

(ii) Collect from each employer the total amount due and make payments to QHP issuers in the SHOP for all enrollees; and

(iii) 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.

(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 either quarterly, monthly, or annually; and

(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 the following requirements of the small group market:

(i) Deductible maximums described in section 1302(c) of the Affordable Care Act; and

(ii) Levels of coverage 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. The SHOP may authorize uniform group participation rules for the offering of health insurance coverage 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.

(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.

**§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.

**§155.715 Eligibility determination process for SHOP.**

(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 eligibility determinations described in sections 1411(b)(2) or 1411(c) of the Affordable Care Act.

(d) Eligibility adjustment period. (1) When the information submitted on the SHOP single employer application is inconsistent with the eligibility standards described in §155.710, 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) For an individual requesting eligibility to enroll in a QHP through the SHOP for whom the SHOP receives information on the application inconsistent with the employer provided information, 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 coverage of the employer's qualified employees enrolled in the 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.

**§155.720 Enrollment of employees into QHPs under SHOP.**

(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;

(6) Processing enrollment of qualified employees into selected QHPs; and

(7) Establishment of effective dates of employee coverage.

(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. The SHOP must ensure that a QHP issuer notifies a qualified employee enrolled in a QHP of the effective date of coverage consistent with §156.260(b).

(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.

**§155.725 Enrollment periods under SHOP.**

(a) General requirements. The SHOP must –

(1) Adhere to the start of the initial open enrollment period set forth in §155.410;

(2) Ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates in accordance with §156.260 of this subchapter; and

(3) Provide the special enrollment periods described in §155.420 excluding paragraphs (d)(3) and (6).

(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.

(c) Annual employer election period. The SHOP must provide qualified employers with a period of no less than 30 days 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. The SHOP must establish a standardized annual open enrollment period of no less than 30 days for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

(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. The SHOP must provide an employee who becomes a qualified employee outside of the initial or annual open enrollment period an enrollment period to seek coverage in a QHP beginning on the first day of becoming a qualified employee.

(h) Effective dates. The SHOP must establish effective dates of coverage for qualified employees consistent with the effective dates of coverage described in §155.720.

(i) Renewal of coverage. If a qualified employee enrolled in a QHP through the SHOP remains eligible for coverage, such employee will remain in the QHP selected the previous year unless –

(1) The qualified employee terminates coverage from such QHP in accordance with standards identified in §155.430;

(2) The qualified employee enrolls in another QHP if such option exists; or

(3) The QHP is no longer available to the qualified employee.

**§155.730 Application standards for SHOP.**

(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 allow an employer to file the SHOP single employer application and employees to file the single employee application in the form and manner described in §155.405(c).

(g) Additional safeguards. 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.

5. Subpart K is added to read as follows:

**Subpart K – Exchange Functions: Certification of Qualified Health Plans**

Sec.



**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.

**§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 justifications. The Exchange must ensure that the QHP issuer has prominently posted the justification on its website 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.

**§155.1040 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.**

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 subtitle, except for multi-State plans. The U.S. Office of Personnel Management will establish the accreditation period for multi-State plans.

**§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 on or before September 15 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, meet 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.

**PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES**

6. The authority citation for part 156 continues to read as follows:

**Authority:** Title I of the Affordable Care Act, Sections 1301-1304, 1311-1312, 1321, 1322, 1324, 1334, 1341-1343, and 1401-1402, Pub. L. 111-148, 124 Stat. 119 (42 U.S.C. 18042).

7. Revise the part 156 heading to read as set forth above.

8. Add subpart A to read as follows:

**Subpart A – General Provisions**

Sec.



**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:

Applicant has the meaning given to the term in §155.20 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.

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.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(2) of the Affordable Care Act of plan coverage.

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.

**§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 Exchanges user fees. A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by the Federally-facilitated Exchange under 31 USC 9701 or a State-based Exchange under §155.160 of this subchapter.

9. Add subpart C to read as follows:

**Subpart C – Qualified Health Plan Minimum Certification Standards**

Sec.

**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 and, in the small group market, §155.705 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in §156.20;

(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 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) and (I) 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 related to the risk adjustment program 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 section 1302(d)(1) of the Affordable Care Act; 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, sex, gender identity or sexual orientation.

**§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 website.

**§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 website and such other means for individuals without access to the Internet.

**§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; and

(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.

**§156.230 Network adequacy standards.**

(a) General requirement. A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards –

(1) Includes essential community providers in accordance with §156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) Access to provider directory. A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange 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.

**§156.235 Essential community providers.**

(a) General requirement. (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer 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.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) Alternate standard. A QHP issuer described in paragraph (a)(2) 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, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) Definition. Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Pub. L. 111-8.

(d) Payment rates. Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(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) would preclude a QHP issuer and federally-qualified health center from mutually 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 such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated 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 Health plan applications and notices.**

QHP issuers must provide all applications and notices to enrollees in accordance with the standards described in §155.230(b) of this subtitle.

**§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 received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

(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.

(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 no less than once a month in accordance with §155.400(d).

(g) Enrollment acknowledgement. A QHP issuer must acknowledge receipt of enrollment information transmitted from the Exchange in accordance with Exchange standards established in accordance with §155.400(b)(2) of this subchapter.

**§156.270 Termination of coverage for qualified individuals.**

(a) General requirement. A QHP issuer may only terminate coverage as permitted by the Exchange in accordance with §155.430(b) of this subchapter.

(b) Termination of coverage notice requirement. If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer must:

(1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with §155.430(d) of this subchapter.

(2) Notify the Exchange of the termination effective date and reason for termination.

(c) Termination of coverage due to non-payment of premium. A QHP issuer must establish a standard policy for the termination of coverage of enrollees 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 coverage:

(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 three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. 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.

(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, the QHP issuer must terminate the enrollee's coverage 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. QHP issuers must abide by the termination of coverage effective dates described in §155.430(d) of this subchapter.

**§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.

**§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) 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 this subparagraph 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.**

(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.

(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 annual employee open enrollment period described in §155.725 of this subchapter;

(2) Provide special enrollment periods described in §155.420 excluding paragraphs (d)(3) and (6);

(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 in accordance with §156.260 and those established through §155.720 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) Provide new enrollees with the enrollment information package as described in §156.265(e);

(4) Reconcile enrollment files with the SHOP at least monthly;

(5) Acknowledge receipt of enrollment information in accordance with SHOP standards; and

(6) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(d) Termination of coverage in the SHOP. QHP issuers offering a QHP through the SHOP must:

(1) Comply with the following requirements with respect to coverage termination of enrollees in the SHOP:

(i) General requirements regarding termination of coverage established in §156.270(a);

(ii) Requirements for notices to be provided to enrollees and qualified employers in §156.270(b) and §156.290(b); and

(iii) Requirements regarding termination of coverage effective dates as set forth in §156.270(i).

(2) If a qualified employer chooses to withdraw from participation in the SHOP, the QHP issuer must terminate coverage for all enrollees of the withdrawing qualified employer.

(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.

**§156.290 Non-renewal and decertification of QHPs.**

(a) Non-renewal of recertification. If a QHP issuer elects not to seek recertification 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 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;

(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 coverage for enrollees in the QHP in accordance with §156.270, as applicable.

(b) Notice of QHP non-renewal. If a QHP issuer elects not to seek recertification with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.

(c) Decertification. If a QHP is decertified by the Exchange, the QHP issuer must terminate coverage for enrollees 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.**

(a) General requirement. In a form, manner, and at such times specified by HHS, a QHP issuer 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, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public, that is paid by the QHP issuer or the QHP issuer's contracted PBM;

(2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding bona fide service fees) that the QHP issuer or its contracted PBM 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]

(3) The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(b) Confidentiality. Information disclosed by a QHP issuer or a PBM under this section is confidential and shall not be disclosed by HHS or by a QHP receiving the information, except that HHS may disclose the information in a form which does not disclose the identity of a specific PBM, QHP, or prices charged for 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.

9. Section 156.505 is amended by--

A. Revising the definitions of "CO-OP qualified health plan," "Exchange," Individual market," "Issuer," "SHOP," "Small group market," and "State."

B. Removing the definitions of "Group health plan," "Health insurance coverage," "Qualified employer," "Qualified health plan," and "Small employer."

The revisions read as follows:

**§156.505 Definitions.**

* * * * *

CO-OP qualified health plan means a health plan that has in effect a certification that it meets the standards described in subpart C of this part, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in §156.520(e).

Exchange has the meaning given to the term in §155.20 of this subchapter.

* * * * *

Individual market has the meaning given to the term in §155.20 of this subchapter.

Issuer has the meaning given to the term in §155.20 of this subchapter.

* * * * *

SHOP has the meaning given to the term in §155.20 of this subchapter.

Small group market has the meaning given to the term in §155.20 of this subchapter.

* * * * *

State has the meaning given to the term in §155.20 of this subchapter.

10. Section 156.510 is amended by revising paragraph (b)(2)(i) to read as follows:

**§156.510 Eligibility.**

* * * * *

(b) * * *

(2) * * *

(i) Has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that also sponsors a pre-existing issuer but is not an issuer, a foundation established by a pre-existing issuer, a holding company that controls a pre-existing issuer, or a trade association comprised of pre-existing issuers and whose purpose is to represent the interests of the health insurance industry, provided that the pre-existing issuer sponsored by the nonprofit organization does not share any of its board or the same chief executive with the applicant; or

* * * * *

**§156.520 [Amended]**

11. Section 156.520 is amended by removing paragraph (e)(1), and redesignating paragraphs (e)(2), (3), and (4) as paragraphs (e)(1), (2), and (3) respectively.

12. Part 157 is added to read as follows:

**PART 157 – EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION**

**Subpart A – General Provisions**

Sec.

157.10 Basis and scope.

157.20 Definitions.

**Subpart B – [Reserved]**

**Subpart C – Standards for Qualified Employers**

157.200 Eligibility of qualified employers to participate in a SHOP.

157.205 Qualified employer participation process in a SHOP.

**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:

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.**

(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) A period to seek coverage in a QHP beginning on the first day of becoming a qualified employee; 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 employees; 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.

**Dated:** March 1, 2012

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**Marilyn Tavenner,**

Acting Administrator,

Centers for Medicare & Medicaid Services.

**Approved:** March 2, 2012

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**Kathleen Sebelius,**

Secretary.

**BILLING CODE 4120-01-P**

**[FR Doc. 2012-6125 Filed 03/12/2012 at 11:15 am; Publication Date: 03/27/2012]**