PATIENT PROTECTION AND AFFORDABLE CARE ACT Establishment of Exchanges and Qualified Health Plans 45 CFR Parts 155 and 156	
	PART 155 – EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS
PAGE	Subpart A – General Provisions
12	**Sec. 155.10 Basis and Scope.** Specifies the general statutory authority for and scope of standards that establish minimum requirements for the State option to establish an Exchange, minimum Exchange functions, enrollment periods, minimum SHOP functions, and certification of Qualified Health Plans (QHPs).
13	**Sec. 155.20 Definitions.** Definitions set forth for terms used throughout Part 155.
PAGE	Subpart B – General Standards Related to the Establishment of an Exchange by a State
19	**Sec. 155.100 Establishment of State Exchange.** (a) Provides each State with the option to elect to establish an Exchange for the individual and small group markets. (b) Exchange must be a governmental agency or non-profit entity established by the State. State should consider the types of governmental agencies that could serve as an Exchange, and should consider the costs and benefits of utilizing the accountability structure within an existing agency versus the need to establish a governing body for an independent public agency. States should consider the relative merits of operating an Exchange through a non-profit entity.
20	**Sec. 155.105 Approval of a State Exchange.** (a) Secretary shall determine by January 1, 2013 whether a State's Exchange will be fully operational by January 1, 2014. Fully operational means an Exchange is capable of beginning operations by October 1, 2013 to support initial enrollment. (b) Outlines standards upon which HHS will approve a State Exchange. (1) Exchange must be established consistent with Regulations and capable of carrying out the required functions of an Exchange. (2) Exchange must be able to comply with the information requirements with respect to advance payments of the premium tax credit. (3) Exchange must agree to perform its responsibilities related to the operation of a reinsurance program. (4) Entire geographic area of a State must be covered by one or more Exchanges. (c) To initiate the State Exchange approval process, a State must elect to establish an Exchange by submitting an Exchange Plan to HHS. Each State applying for approval of its Exchange is subject to an assessment to be carried out by HHS to evaluate a State's operational readiness to execute its Exchange Plan. (d) Each State must receive written approval or conditional approval of its Exchange Plan in order to be approved to operate. (e) State must notify HHS before significant changes are made to the Exchange Plan and an Exchange must receive written approval of significant changes from HHS before they may be effective. (f) If a State elects not to establish an Exchange, or if 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.
24	**Sec. 155.106 Election to operate an Exchange after 2014.** (a) Approval process for States that do not have in place an approved or conditionally approved Exchange Plan and operational readiness assessment by January 1, 2013. Proposes to allow States the flexibility of seeking approval to operate an Exchange even if the State is not

	approved by January 1, 2013. State must work with HHS to develop a plan to transition from a Federally-facilitated Exchange to a State Exchange. (b) Process to allow a State-operated 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.
25	**Sec. 155.110 Entities eligible to carry out Exchange functions.** (a) Provides Exchange with the authority to contract with eligible entities to carry out responsibilities of the Exchange. An eligible entity is one that: (1) Is incorporated under and subject to the laws of one or more States; (2) Has demonstrated experience on a State or regional basis in the individual and small group markets and in benefits coverage; (3) Is not a health insurance issuer or treated as a health insurance issuer. An eligible entity includes the State Medicaid agency. (b) Exchange remains responsible for meeting all Federal requirements related to contracted functions. (c) If Exchange is an independent State agency or non-profit entity established by the State, it must have a clearly defined governing board. (1) Exchange accountability structure must be administered under a formal, publicly-adopted operating charter. (2) Exchange board must hold regular public meetings with advance notice requirements. (3) Standards for membership on the Exchange governing board related to conflicts of interest and management qualifications. (4) Exchange governing body ensures that a majority of members have relevant experience. (d) Requirements related to governance principles of an Exchange. (1) Each Exchange must publish a set of guiding governance principles that includes ethical and conflict of interest standards. (2) Each Exchange must have procedures for disclosure of financial interest by members of the governing body. (e) State retains option to elect to establish a separate governance and administrative structure for the SHOP. However, a single governance structure will yield better policy coordination, increased operational efficiencies, and improved operational coordination. (f) HHS may periodically review the accountability structure and governance principles of an Exchange.
29	**Sec. 155.120 Non-interference with Federal law and non-discrimination standards**. (a) Exchange may not establish rules that conflict with or prevent the application of Exchanges regulations promulgated by HHS. (b) 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. (c) State must comply with any applicable non-discrimination statutes.
30	**Sec. 155.130 Stakeholder consultation**. Exchange must consult on an ongoing basis with key stakeholders. Each Exchange that has one or more Federally-recognized tribes located within the Exchange's geographic area must engage in regular, meaningful consultation and collaboration with such tribes and tribal officials.
32	**Sec. 155.140 Establishment of a regional Exchange or subsidiary Exchange.** Provides for the operation of an Exchange in more than one State if each State permits such operation and the Secretary approves such an Exchange. (a) States may participate in a regional Exchange if the Exchange spans two or more States – States need not be contiguous. (b) States may establish one or more subsidiary Exchanges if each such Exchange serves a geographically distinct area (must also meet size requirements).

	(c) Basic standards for a regional or subsidiary Exchange.
34	**Sec. 155.150 Transition process for existing State health insurance Exchanges.** (a) States operating an existing 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 (current estimate is 93.6%). (b) States currently operating an exchange must work with HHS to identify areas of non-compliance with the requirements of this part.
35	**Sec. 155.160 Financial support for continued operations.** (a) State must ensure its Exchange has sufficient funding to support ongoing operations beginning January 1, 2015 (self-sustaining). (b) State Exchanges may fund ongoing operations by charging user fees or assessments on participating issuers. Provides states with broad flexibility to generate funds beyond assessments or user fees – including general State revenues, provider taxes, or other funding. State Exchange must be self-sustaining starting on January 1, 2015 – Federal Funds may not be provided after that time to support its continued operations.
PAGE	Subpart C – General Functions of an Exchange
37	**Sec. 155.200 Functions of an Exchange.** (a) Establishes a general standard that an Exchange must perform the required functions set forth in Subparts C, E, H, and K. (b) Exchange must grant certifications of exemptions from the individual responsibility requirement and payment. (c) Exchange must perform eligibility determinations. (d) Exchange must establish a process for appeals of eligibility determinations. (e) Exchange must perform required functions related to oversight and financial integrity requirements in order to comply with PPACA. (f) 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.
39	**Sec. 155.205 Required consumer assistance tools and programs of an Exchange.** (a) Exchange must provide for the operation of a call center to respond to requests for assistance by consumers that is accessible via a toll free telephone number. (b) Exchange must maintain an internet website (lists specific up-to-date information which must be included). (1) Secretary must establish a standardized format for presenting coverage option information. (2) Secretary must make available a model Exchange website template developed by the Secretary. (c) Requires Exchange to establish an electronic calculator to assist individuals in comparing costs of coverage. (d) Exchange must have a consumer assistance function that provides assistance services to consumers. (e) Requires the Exchange to conduct outreach and education activities to educate consumers about the Exchange and to encourage participation. Exchanges should aim to maximize enrollment of eligible individuals.
45	**Sec. 155.210 Navigator program standards.** (a) Exchanges must award grant funds to public or private entities to serve as Navigators. (b) Eligibility requirements for and the types of entities to which the Exchange may award Navigator grants. (c) Codifies the statutory prohibitions on Navigator conduct in the Exchange. Health insurance issuers are prohibited from serving as

	Navigators and Navigators must not receive any consideration from any health insurance issuer in connection with enrollment. (d) Minimum duties of a Navigator. (e) Exchange is prohibited from supporting the Navigator program with Federal funds received by the State for the establishment of Exchanges. Exchange must use operational funds generated through non-Federal sources.
49	**Sec. 155.220 Ability of States to permit agents and brokers to assist qualified individuals enrolling in QHPs.** (a) Gives States the option to permit agents or brokers to assist individuals enrolling in QHPs through the Exchange. (b) Permits an Exchange to display information about agents and brokers on its website or other publicly available materials.
50	**Sec. 155.230 General standards for Exchange notices.** (a) Any notice sent by an Exchange must be in writing and include: contact information for customer service resources; an explanation of rights to appeal; and a citation to the specific regulation serving as the cause for notice. (b) All applications, forms and notices must be provided in plain language. (c) Exchange must annually re-evaluate the appropriateness and usability of the applications, forms and notices.
51	**Sec. 155.240 Payment of premiums.** Exchange generally has three options for method of premium payment: (1) Take no part in payment of premiums (enrollees pay premiums directly to a QHP issuer); (2) Facilitate the payment of premiums by creating an electronic "pass through" without directly retaining any of the payments; (3) Establish a payment option where the Exchange collects premiums from enrollees. (a) An Exchange may exercise any of the options listed above, but it must always allow an individual to pay directly to the QHP issuer if he or she chooses, regardless of other premium payment options. (b) Exchange may permit Indian tribes or tribal organizations to pay the QHP premiums on behalf of qualified individuals. (c) In the operation of a SHOP, an Exchange must accept payment of an aggregate premium by a qualified employer. (d) Exchange may facilitate through electronic means the collection and payment of premiums. (e) Exchanges choosing to offer enrollees payment through electronic means must conform to any standards and protocols. **Note that premium collection by the Exchange does not make the Exchange liable for payment.
54	**Sec. 155.260 Privacy and security of information.** All Exchanges must apply appropriate security and privacy protections when collecting, using, disclosing or disposing of personally identifiable information it collects. (a) "Personally Identifiable Information" is information that alone or when combined with other personal or identifying information which is linked or linkable to a specific individual, can reasonably be used to distinguish an individual's identity. (b) Collection, use and disclosure of personally identifiable information is limited to what is specifically required or permitted. Security standards of the Exchange should be consistent with HIPAA security rules. 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. (c) Exchange must participate in the data matching program required by PPACA. (d) Exchanges must adopt privacy and security policies and procedures that meet the standards in Section 6103 of the Code that protect the confidentiality of tax returns and tax return information.

59	**Sec. 155.270 Use of standards and protocols for electronic transactions.** (a) HIPAA administrative simplification requirements must be used for development and operation of Exchange IT systems. (b) Codify HIT enrollment standards and protocols developed pursuant to the PHS Act.
PAGE	Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans
61	**Sec. 155.400 Enrollment of qualified individuals into QHPs.** (a) Exchanges must accept a QHP selection from an applicant who is determined eligible for enrollment in a QHP; notify the issuer of the applicant's selected QHP; and transmit information necessary to enable the QHP issuer to enroll the applicant. (b) Exchanges must send QHP issuers enrollment information on a timely basis (ideally real-time basis). (c) Exchanges must maintain records of enrollment, submit enrollment information to HHS, and reconcile the enrollment files with the QHP issuers no less than on a monthly basis.
61	**Sec. 155.405 Single streamlined application.** (a) Exchange should use a single streamlined application to collect information necessary for QHP enrollment, advance payments of premium tax credit, cost-sharing reductions, and Medicaid, and CHIP. (b) If the Exchange seeks to use an alternative application, it must be approved by HHS. Intent is to simplify the application process and reduce the collection of extraneous information. (c) Exchange must accept applications from multiple sources, including the applicant; an authorized representative; or someone acting responsibly for the applicant. Applications may be filed online, via telephone, by mail, or in person.
63	**Sec. 155.410 Initial and annual open enrollment periods.** (a) Exchanges should adhere to the initial and annual open enrollment periods in this section and indicate that qualified individuals and enrollees begin or change coverage in a QHP at such times. Exchanges may only permit a qualified individual to enroll in a QHP or an enrollee to change QHPs during the initial open enrollment period. (b) The initial open enrollment period to enroll in a QHP will be from October 1, 2013 through February 28, 2014. (c) Rules regarding the effective date of coverage for the initial open enrollment period. (1) For a QHP selection received by the Exchange on or before December 22, 2013, the Exchange must ensure an effective date of January 1, 2014. (2) For a QHP selection received between the first and twenty-second day of any subsequent month during the initial open enrollment period, the Exchange must ensure an effective date on the first day of the following month. (3) For a QHP selection received between the twenty-third and last day of the month for any month between December, 2013 and February 28, 2014, the Exchange must ensure an effective date of either the first day of the following month or the first day of the second following month. (d) Exchange must send written notification to enrollees about the annual open enrollment period. (e) Propose an open enrollment period from October 15 – December 7 of each year, starting in October 2014. (f) 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.

67	**Sec. 155.420 Special enrollment periods.** (a) 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. (b)Effective dates for QHP selections based on special enrollment periods should follow the proposed effective dates for QHP selections during the initial or annual open enrollment periods. (c) Each special enrollment period will be a standard length of 60 days from the date of the triggering event unless the applicable regulation provides otherwise. (d) Proposed special enrollment periods. (1) Exchange must permit qualified individuals to enroll in a QHP due to loss of other minimum essential coverage; (2) Special enrollment period for a qualified individual who gains a dependent or becomes a dependent; (3) Special enrollment upon gaining status as a citizen, national, or lawfully present individual in the US; (4) Special enrollment for qualified individuals who experience an error in enrollment; (5) Special enrollment for an individual enrolled in a QHP who 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 such individual; (6) Special enrollment for individuals who are newly eligible or have a change in cost-sharing reductions; (7) If new QHPs offered through the Exchange are available to a qualified individual or enrollee as a result of a permanent move, such enrollee receives a special enrollment period; (8) Special enrollment period that Indians receive a monthly special enrollment period; (9) Special enrollment period for exceptional circumstances as determined by the Exchange or HHS. (e) Loss of coverage does not include failure to pay premiums on a timely basis, including COBRA premiums. (f) Upon qualifying for a special enrollment period, the Exchange may only allow an existing enrollee of a QHP to change plans within levels of coverage as defined by PPACA.
75	**Sec. 155.430 Termination of coverage.** (a) Exchange must determine the form and manner in which coverage in a QHP may be terminated. (b) Set of events that would cause an enrollee's coverage in a QHP to be terminated: (1) Exchange must permit an enrollee to terminate his or her coverage with appropriate notice to Exchange or QHP; (2) Exchange may terminate an enrollee's coverage in a QHP and must permit a QHP issuer to terminate such coverage when: a. Enrollee is no longer eligible for coverage in a QHP through the Exchange; b. Enrollee becomes covered in other minimum essential coverage; c. Payments of premiums for coverage of the enrollee cease; d. Enrollee's coverage is rescinded; e. QHP terminates or is decertified by the Exchange; f. Enrollee changes from one QHP to another during the annual open enrollment period, or special enrollment period. (c) Exchange must establish maintenance or records procedures for termination or coverage, track the number of individuals terminated, establish terms for reasonable accommodations, and retain records in order to facilitate audit functions. (d)Standards for the effective dates for termination of coverage.

	(1) Termination requested by an enrollee – the last day of coverage for an enrollee is the termination date specified by enrollee; (2) Termination by the Exchange or QHP as a result of enrollee obtaining new minimum coverage – last day of coverage is the day before the effective date of the new coverage. (3) Termination by the Exchange or QHP as a result of an enrollee changing QHPs – the last day of coverage in the enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.
77	**Sec. 155.440 [Reserved]**
PAGE	Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)
78	**Sec. 155.700 Standards for the establishment of a SHOP.** 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 the qualified health plans. **Note that participation in a SHOP is strictly voluntary for small employers.
78	**Sec. 155.705 Functions of a SHOP.** (a) SHOP must carry out all the required functions of an Exchange described in Subparts C, E, H, and K. (1) SHOP does not need to meet the requirements related to individual eligibility determinations. (2) SHOP does not need to comply with the requirements related to enrollment of qualified individuals into QHPs. (3) SHOP does not need to include the calculator described in 155.205(c). (4) SHOP does not need to certify exemptions from the individual coverage requirement. (5) Requirements related to the payment of premiums by individuals, Indian tribes and tribal organizations do not apply to SHOP. (b) Unique Functions of the SHOP. (1) SHOP must adhere to unique enrollment and eligibility requirements. (2) All special enrollment periods that apply in the Exchange in connection with individual market coverage apply in the SHOP. (3) Provides flexibility for Exchanges and their SHOPs to choose additional ways for qualified employers to offer one or more plans to their employees. (4) Contains standards related to premium aggregation by the SHOP. (5) With respect to QHP certification, QHPs must meet the requirements described in 156.285. (6) Contains standards for rates and rate changes (must be made a uniform time that is either quarterly, monthly, or annually). (7) If a State merges the individual and small group risk pools, the Exchange may only offer employers and employees QHPs that meet the SHOP requirements for QHPs. (8) If a State does not merge the individual and small risk pools, a SHOP may only make small group QHPs available to qualified employees. (9) States may allow insurers in the large group market to offer health plans inside of the SHOP beginning in 2017.
84	**Sec. 155.710 Eligibility standards for SHOP.** (a) SHOPs must make QHPs available to qualified employers. (b) Eligibility criteria for qualified employers. (1) SHOP must ensure that an entity is a small employer (no more than 100 employees). (2) SHOP must ensure a qualified employer provides an offer of coverage through a SHOP to all full-time employees.

	(3) Employer can elect to cover all employees through the SHOP serving the employer's principal business address. (c) Requires SHOPs to accept the application of an employer to provide coverage to eligible employees whose worksite is in the SHOP service area if the employer elects to cover all employees through the SHOP serving their worksites. (d) Allows employers participating in a SHOP to continue participating in the SHOP if the number of workers employed exceeds the level specified by the definition of a qualified employer after the employer's initial eligibility determination. (e) Eligibility criteria for a qualified employee. Only employees that receive an offer of coverage through the SHOP from a qualified employer may be a qualified employee.
87	**Sec. 155.715 Eligibility determinations process for SHOP.** (a) Eligibility determination process for employers seeking to offer qualified employees health coverage through a SHOP. We propose that a SHOP determine eligibility consistent with the standards described above in 155.710. (b) SHOP may only use two application forms: one for qualified employers and one for qualified employees. (c) In determining eligibility in the SHOP, the SHOP may use the information attested to by the employer or employee on the application. The SHOP must at a minimum, verify that an individual attempting to enter the SHOP is listed on the qualified employer's roster of employees to whom coverage is offered. (d) SHOP must have processes to resolve occasions when the SHOP has a reason to doubt the information provided through the employer and employee applications. (e) SHOP must notify an employer of the SHOP's eligibility determination and the employer's right to appeal. (f) SHOP must notify an employee of the SHOP's eligibility determination and the employee's right to appeal. (g) 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 the 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.
89	**Sec. 155.720 Enrollment of employees into QHPs under SHOP.** (a) SHOP must process applications for enrollment from employees and facilitate enrollment of qualified employees into QHPs. (b) SHOP must establish a uniform enrollment timeline and process to be followed by all employers and QHPs in the SHOP. (c) SHOP must process applications in accordance with the timeline described in paragraph (b) and adhere to requirements regarding relevant standards for enrollment and timing of data exchange between the SHOP and QHPs. (d) SHOP must adhere to standards set forth regarding administration. (e) SHOP must ensure that qualified employees who select a QHP are notified of the effective date of coverage. (f) & (g) Address the maintenance of enrollment records and reconciliation of enrollment information with QHPs. (h) If a qualified employee voluntarily terminates coverage from a QHP, the SHOP must notify the individual's employer.
91	**Sec. 155.725 Enrollment periods under SHOP.** (a) SHOP must: (1) Adhere to the start of the initial open enrollment period for the Exchange; and (2) Ensure that enrollment transactions are sent to QHP issuers and that such issuers adhere to coverage effective dates. (b) Proposes a rolling enrollment process in the SHOP whereby qualified employers may begin participating in the SHOP at any time during the year. Note that qualified employers may enter the SHOP at any time, qualified employees will only be able to enroll or change plans once

	a year unless such employees qualify for a special enrollment period. (c) Proposes an annual employer election period in advance of the annual open enrollment period during which time qualified employers can modify the employer contribution towards the premium cost of coverage and plan offerings. (d) SHOP must notify participating employers that their annual election period is approaching. (e) SHOP must establish an annual employee open enrollment period for qualified employees. (f) SHOP must ensure that a qualified employee hired outside of the initial or annual open enrollment period will have a specified window set by the SHOP to seek coverage in a QHP beginning on the first day of employment. (g) SHOP must establish effective dates of coverage for qualified employees. (h) If an enrollee remains eligible for coverage in a QHP through the SHOP, such individual will remain in the QHP selected during previous plan year with limited exceptions.
94	**Sec. 155.730 Application standards for SHOP.** (a) General requirement that SHOP applications adhere to the application standards set forth in this section. (b) SHOP must use a single employer application to determine employer eligibility and to collect the information necessary for the employer to purchase coverage through the SHOP. (c) SHOP must use a single employee application for each employee to collect eligibility and QHP selection and enrollment information from employees seeking to enroll in a QHP. (d) SHOPs may use a model single employer application and model single employee application created by HHS. (e) Permits SHOPs to use an alternative employer application with approval by HHS. (f) SHOP must allow employer and employees to submit their eligibility and enrollment information consistent with 155.405.
PAGE	Subpart K – Exchange Functions: Certification of Qualified Health Plans
97	**Sec. 155.1000 Certification standards for QHPs.** (a) Defines a multi-state plan. (b) Exchanges may not make available any health plan that is not a QHP. Offering only QHPs will assure consumers that the coverage options presented through the Exchange meet minimum standards. (c) Codifies two basic sets of requirements that an Exchange must ensure that a health plan meets to be certified as a QHP issuer. (1) Provides minimum QHP certification requirements to be applied by an Exchange (Subpart C of Section 156) (2) Allows an Exchange to certify a health plan if it determines it is in the interest of qualified individuals and qualified employers in the State. Follows comments regarding "any willing plan" model. (3) Outlines prohibitions on the Exchanges when it is making the determination that a health plan is in the interest of qualified individuals and qualified employers. Exchange cannot exclude plans: a. On the basis that the plan is a fee-for-service plan; b. Through the imposition of premium price controls; or c. On the basis that the health plan provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.

101	**Sec. 155.1010 Certification process for QHPs.** (a) Exchange shall establish procedures for the certification of QHPs consistent with criteria outlined in 155.1000. (b) Requires a multi-State plan offered through OPM to be deemed as certified by an Exchange. (c) Exchange shall complete the certification of QHPs prior to the open enrollment periods established in 155.410. (d) Exchange must monitor the QHP issuers for demonstration of ongoing compliance with the certification requirements.
102	**Sec. 155.1020 QHP issuer rate and benefit information.** (a) 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 website. (b) Exchange must consider the following factors related to health plan rates when determining whether to certify QHPs: (1) Justification of a rate increase prior to the implementation of the increase; (2) Recommendations provided to the Exchange by the State; and (3) Any excess rate growth outside the Exchange as compared to the rate of growth inside the Exchange. (c) Exchange must at least annually receive the following information from the QHP issuers' for each QHP: rates, covered benefits, and cost-sharing requirements.
104	**Sec. 155.1040 Transparency in coverage.** (a) Exchanges will be required to collect information from QHP issuers relating to coverage transparency. (b) Exchanges will monitor the use of plain language by QHP issuers when making available QHP transparency data. (c) Exchanges shall require QHP issuers to make available cost-sharing information to enrollees.
106	**Sec. 155.1045 Accreditation timeline.** Establishes the time period within which any QHP issuer that is not already accredited must become accredited following certification of a QHP. Accreditation acts as a "seal of approval" to indicate to individuals and employers that a health insurance issuer meets minimum standards of quality and consumer protection. Exchange must establish the length of time following initial certification of a QHP within which a QHP issuer must become accredited and the Exchange must establish a consistent deadline for accreditation with respect to each QHP issuer's initial participation in the Exchange.
107	**Sec. 155.1050 Establishment of Exchange network adequacy standards.** Under PPACA, HHS is required to establish network adequacy requirements for health insurance issuers seeking certification as QHPs. Each Exchange shall ensure that enrollees of QHPs have a sufficient choice of providers. This proposed standard will allow Exchanges to set standards appropriate to local patterns of care. Exchanges are urged to consider the needs of enrollees in isolated areas.
109	**Sec. 155.1055 Service area of a QHP.** Exchanges must have a process to establish or evaluate the services areas of QHPs. Exchanges will maintain discretion to pre-determine service areas for plans to cover, permit plans to propose coverage of certain service areas, or negotiate with issuers over service areas during the certification process. (a) Exchange must ensure that the services area of a QHP covers at least a county, or a group of counties, unless the QHP issuer demonstrates that serving a partial county is necessary, nondiscriminatory, and in the interest of qualified individuals and employers. (b) Exchange must ensure that QHP services areas are established without regard to racial, ethnic, language and health status factors.

110	**Sec. 155.1065 Stand-alone dental plans.** (a) Exchanges shall allow limited scope stand-alone dental plans to be offered provided that the plan furnishes at least the pediatric essential dental benefits required in PPACA. (b) Allows for the option of a dental plan to be offered as a stand-alone plan or in conjunction with a QHP. (c) Allows a health plan to be certified as a QHP if it does not offer the pediatric essential dental benefit provided a stand-alone dental plan is offered through the Exchange.
112	**Sec. 155.1075 Recertification of QHPs.** Recertification provides a process for an Exchange to conduct a comprehensive review of its QHPs. (a) Exchanges must establish a process for recertification of QHPs that includes a review of the general certification criteria (155.1000). An Exchange has the discretion to decide to recertify QHPs annually, or on a less frequent basis. (b) Exchange must complete the recertification process on or before September 15 of the applicable calendar year (recertification should be completed in advance of the annual open enrollment period).
114	**Sec. 155.1080 Decertification of QHPs.** (a) Defines decertification as the termination by the Exchange of the certification status and offering of a QHP. (b) Requires the Exchange to implement procedures for the decertification of health plans as QHPs. (c) Exchanges may at any time decertify a QHP if the Exchange determines that the QHP issuer or the QHP is no longer acting in accordance with the general certification criteria. The Exchange will have discretion in determining how to implement the decertification process. (d) Exchange shall establish an appeals process for health plans that have been decertified by the Exchange. (e) If a QHP is decertified, the Exchange must provide notice of the decertification to parties who may be affected.
	PART 156 – HEATH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES
PAGE	Subpart A – General Provisions
115	**Sec. 156.10 Basis and scope.** Specifies the general statutory authority for the ensuing regulation and indicates 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.
116	**Sec. 156.20 Definitions.** Definitions set forth for terms used throughout Part 156.
116	**Sec. 156.50 Financial Support.** Contains requirements on participating issuers to pay user fees to support ongoing operations of an Exchange, if a State chooses to impose fees. A State-operated Exchange must be self-sustaining by January 1, 2015. (a) Participating User means an issuer offering plans that participate in the specific function that is funded by the user fee. This definition encompasses different segments of issuers of health plans or benefit plans depending on the Exchange function being funded by the user. (b) Participating issuers shall pay any fees assessed by a State Exchange.

PAGE	
	Subpart B – [Reserved]
	Subpart C – Qualified Health Plan Minimum Certification Standards
118	**Sec. 156.200 QHP issuer participation standards.** **Note that if a State establishes a higher standard for licensure than what is outlined as a minimum Federal requirement for health plan certification, such standard would apply. (a) 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 requirements on QHP issuers. (b) Outlines the set of standards with which a QHP issuer must comply related to the offering of a QHP: (1) QHP issuers must comply with the requirements set forth in this subpart on an ongoing basis. (2) QHP issuers must comply with any Exchange processes, procedures, and standards set forth for the small group market. (3) QHP issuers must ensure that each QHP it offers complies with the benefit design standards defined in 156.20. (4) QHP issuers must be licensed and in good standing to offer health insurance coverage in each State in which such issuer offers health insurance coverage. (5) QHP issuers must comply with quality standards established in PPACA. (6) QHP issuers must adhere to additional proposed requirements including user fees and the risk adjustment participation requirements. (c) Outlines the requirements on QHP issuers related to the offering of QHPs. (1) Requires each QHP issuer offer at least one QHP in the silver coverage level and at least one QHP in the gold coverage level. (2) Any QHP issuer offering a non-catastrophic health plan in the Exchange must offer the identical plan as a child-only health plan. (3) QHP issuers must offer a QHP at the same premium rate consistent with the requirements in 156.255. (d) QHP issuers must adhere to the requirements of this subpart and any additional participation standards that may be applied by the Exchange or the State. (e) QHP issuers must not discriminate based on race, color, national origin, disability, age, sex, gender identity and sexual orientation.
121	**Sec. 156.210 QHP rate and benefit information.** (a) A QHP's rates must be applicable for an entire benefit year or, for the SHOP plan year. (b) The QHP issuer must submit rate and benefit information to the Exchange. (c) The QHP issuer must submit a justification for a rate increase prior to implementation of the rate increase. **Note – Would also like codify the rate transparency requirement which requires that issuers post the rate increase justifications on their websites so they can be viewed by consumers and enrollees.
122	**Sec. 156.220 Transparency in coverage.** (a) & (b) Establishes a transparency standard as a condition for certification of QHPs. To receive and maintain certification, health insurance issuers must make available to the public and submit to the Exchange a broad range of information relevant to the plan's quality and cost. (c) Requires QHP issuers to provide the information required above in plain language. (d) Requires QHP issuers to make available information on cost-sharing responsibilities for a specific service by a participating provider under that enrollee's plan.

123	**Sec. 156.225 Marketing of QHPs.** (a) Requires QHP issuers to comply with any applicable State laws and regulations regarding marketing by health insurance issuers. (b) Prohibits QHP issuers from employing marketing practices that have the effect of discouraging enrollment of individuals with significant health needs. **Note – States and Exchanges may adopt additional requirements for the marketing of health plans that are most appropriate to the unique market dynamics in that State, both inside and outside the Exchange.
125	**Sec. 156.230 Network adequacy standards.** (a) Describes the minimum criteria for network adequacy that health plans must meet to be certified as QHPs. (1) QHP issuers must maintain networks for QHPs that include essential community providers. (2) QHP issuers must maintain networks that comply with any network adequacy standards established by the Exchange. (3) A QHP issuer must ensure that the provider network of its QHPs must be consistent with the provisions of the PHS Act. (b) QHP issuer must make its health plan provider directory available to the Exchange electronically and to potential enrollees and current enrollees in hard copy upon request.
126	**Sec. 156.235 Essential community providers** Requires that a health plan's network include essential community providers who provide care to predominantly low-income and medically-underserved populations to be certified as a QHP. (a) Require that QHP issuers include in their provider networks a sufficient number of essential community providers, where available that serve low-income, medically-underserved individuals. (b) Specifies the types of providers included in the definition of an essential community provider. (1) Defines essential community providers to include all health care providers defined in section 340B(a)(4) of the PHS Act.
132	**Sec. 156.245 Treatment of direct primary care medical homes.** Permits a QHP issuer to provide coverage through a direct primary care medical home that meets the requirements established by HHS, provided that the QHP meets all requirements otherwise applicable. The term "direct primary care medical home plan" means an arrangement where a fee is paid by an individual directly to a medical home for primary care services.
133	**Sec. 156.250 Health plan application and notices.** Establishes basic standards for the format of application and notices provided by the QHP issuer to the enrollee. QHP issuers will be required to provide enrollees with a variety of applications and notices in accordance with the standards for enrollment and termination of coverage.
134	**Sec. 156.255 Rating variation.** (a) Requires States establish one or more rating areas within a State, subject to the Secretary's approval. Permitting premium variation by geographic rating area enables health insurance issuers to account for regional variation in health care costs. (b) Each QHP issuer must 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. (c) Issuers may vary premiums among no more than four different types of family composition that are common among health insurance issuers currently: individual; two adults; adult plus child or children; and a catch-all "family" category. QHP issuers must cover all of these four groups, but in doing so may combine some of the identified categories.

136	**Sec. 156.260 Enrollment periods for qualified individuals.** (a) QHP issuers must accept and enroll qualified individuals in QHPs only during the enrollment periods. (1) QHP issuers must accept and enroll qualified individuals during the initial enrollment period, and during the annual open enrollment period thereafter. (2) QHP issuers must accept and enroll qualified individuals in QHPs if they are granted a special enrollment period. (b) Requires QHP issuers to provide enrollees with notice of their effective date of coverage and such notice must correspond with the effective dates established in 155.410 and 155.420.
137	**Sec. 156.265 Enrollment process for qualified individuals.** (a) QHP issuers must adhere to the Exchange's process for enrollment in QHPs, which includes standards for the collection and transmission of enrollment information. (b) Applications. (1) QHP issuers shall use the application adopted pursuant to 155.405 when accepting applications from individuals seeking to enroll in a QHP through the Exchange enrollment process. (2) After collecting the uniform enrollment information from an applicant, the QHP issuer must send the information to the Exchange. (3) The QHP issuer may enroll the individual in a QHP only after it has received confirmation from the Exchange that the eligibility determination is complete and the applicant is a qualified individual. (c) QHP issuers shall receive enrollment information electronically from the Exchange in a format and manner that is consistent with the standards established in 155.260 and 155.270. (d) QHP issuer must abide by the premium payment process established by the Exchange. (e) QHP issuers must provide enrollees in the Exchange with an enrollment packet. (f) QHP issuers must provide the summary of benefits and coverage document to qualified individuals. (g) QHP issuers must reconcile enrollment files with the Exchange no less than once a month. (h) QHP issuers must acknowledge receipt of enrollment information in accordance with Exchange standards.
139	**Sec. 156.270 Termination of coverage for qualified individuals.** (a) QHP issuer may only terminate coverage as permitted by the Exchange in accordance with 155.430, which includes non-payment of premiums, fraud and abuse, and relocation outside of the service area. (b) QHP issuers must provide a notice of termination of coverage to the enrollee and the Exchange that is consistent with the standards for effective dates in 155.430. (c) QHP issuers must develop a uniform policy as permitted by the Exchange for the termination of coverage due to non-payment of premiums. (d) Standards for the application of a three-month grace period (for non-payment of premiums) for enrollees receiving advance payments of the premium tax credit. (e) QHP issuers must provide notice to all enrollees who are delinquent on premium payments. (f) If enrollee receiving advance payments of premium tax credit exhausts the grace period without submitting any premium payment, the QHP issuer may terminate coverage effective at the completion of the three-month period. (g) QHP issuers must maintain records of termination of coverage in accordance with Exchange standards.

	(h) QHP issuers must abide by the effective dates for termination of coverage as described in 155.430.
141	**Sec. 156.275 Accreditation of QHP issuers.** (a)(1) Codifies the statutory requirement that a QHP issuer be accredited on the basis of local performance in each of the nine categories listed under section 1311(c)(1)(D)(i) of the Affordable Care Act. "Local performance" means the performance of the QHP issuer in the State in which it is licensed. (a)(2) Requires QHP issuer to authorize the accrediting entity to release certain materials related the QHP issuer's accreditation (i.e. a copy of its most recent accreditation survey) to the Exchange and to HHS. (b) Requires QHP issuer to obtain its accreditation with a time period established by the Exchange.
142	**Sec. 156.280 Segregation of funds for abortion services.** Federal funds cannot be used for abortion services (except in the cases of rape or incest, or when the life of the woman would be endangered). This codification also 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, and the associated communication requirements related to such services.
143	**Sec. 156.285 Additional standards specific to the SHOP.** (a) Rating and premium payment requirements for QHP issuers in the SHOP. (1) QHP issuer must accept payment of premiums for the SHOP. (2) QHP issuers must abide by the rate setting timeline established by the SHOP. (3) QHP issuers must charge the same contract rate for a plan year. (b) Requirements for QHP issuers must be consistent with SHOP enrollment periods. (c) QHP issuers must abide by the SHOP enrollment process requirements and timeline, established pursuant to 155.720. (d) 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 form the individual market.
145	**Sec. 156.290 Non-renewal and decertification of QHPs.** (a) Requirements on QHP issuers that elect to not seek recertification with the Exchange. (1) QHP issuer must notify the Exchange prior to the beginning of the recertification process adopted by the Exchange. (2) QHP issuer must continue covering benefits for each enrollee until the completion of the benefit year or plan year for the SHOP. (3) QHP issuer must continue providing the Exchange with reporting information for the benefit or plan year even after withdrawing its QHP from the Exchange. (4) QHP issuer must provide notice of the non-renewal to enrollees of the QHP. (5) QHP issuer must terminate coverage for enrollees in accordance with the applicable requirements in 156.270. (b) Requires all QHP issuers that elect not to seek recertification to provide a written notice to each enrollee. (c) If an Exchange decertifies a QHP, the QHP issuer must terminate coverage for the QHP enrollees only after the Exchange has notified the QHP's enrollees and enrollees have had the opportunity to enroll in other coverage.

147	**Sec. 156.295 Prescription drug distribution and cost reporting.** (a) QHP issuer must report to HHS in a form and manner to be determined by HHS, the following information: (1) 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. (2) Aggregate amount and types of rebates, discounts, or price concessions that the PBM negotiates that are attributable to patient utilization under the plan, and the amount of rebates, discounts, or price concessions that are passed through to the plan sponsor, and the total number of prescriptions that were dispensed; and (3) Aggregate amount of the difference between the amount the QHP issuer pays the 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 requirements to ensure that this information is not disclosed by either HHS or the QHP issuer except under certain circumstances.