HHS Notice of Proposed Rulemaking: Establishment of Exchanges and Qualified Health Plans

Clarifications and suggestions contained in the preamble are noted in *italics.*
Requests for comment are noted in *blue italics*.

Section	Summary	Questions/Comments
Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act		
Subpart A—General Provisions		
§155.20-Definitions	Advance payments of the premium tax credit means payment of the tax credits provided on an advance basis to an eligible individual of a QHP through an Exchange.	
	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 through an application to the Exchange for at least one of the following: (i) Enrollment in a QHP through the Exchange; (ii) Advance payments of the premium tax credit and cost-sharing reductions; or (iii) Medicaid, CHIP, and the BHP, if applicable. (2) An employer or employee seeking eligibility for enrollment in a QHP through the SHOP, where applicable.	
	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 who is enrolled in a QHP in the Exchange.	
	Eligible employer-sponsored plan means, with respect to any employee, a group health plan or group health insurance coverage offered by an employer to the employee which is – (1) A governmental plan; or (2) Any other plan or coverage offered in the small or large group market within a State. Such term shall include a grandfathered health plan offered in the group market.	

Section	Summary	Questions/Comments
	Employer has the meaning given to the term in section 2791 of the PHS Act, except that such term must include 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 must be treated as one employer. *The preamble states that "We note that coverage for only a sole proprietor, certain owners of S corporations, and certain relatives of each of the above would not constitute a group health plan under ERISA section 732(a)… and would not be entitled to purchase in the small group market under Federal law."*	
	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 requirements 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 service area means the area in which the Exchange is certified to operate.	
	Health plan means health insurance coverage and a group health plan. It does not include a group health plan or multiple employer welfare arrangement to the extent the plan or arrangement is not subject to State insurance regulation under section 514 of the Employee Retirement Income Security Act of 1974. *The preamble notes that PPACA specified that a health plan does not include a group health plan or MEWA to the extent that it is not subject to state regulation, but that ERISA allows state regulation of MEWAs to the extent that such regulation does not conflict with ERISA. It requests comment on this inconsistency, as well as whether or not Taft-Hartley plans and church plans can participate in the Exchange.*	
	Individual market means the market for health insurance coverage offered to individuals other than in connection with a group health plan.	
	Initial 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."	
	Navigator means a private or public entity or individual that is qualified, and licensed, if appropriate, to engage in the activities and meet the requirements described in §155.210.	
	Plain language means language that the intended audience, including individuals with limited English proficiency, can readily understand and use because that language is concise, well organized, and follows other best practices of plain language writing.	
	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.	

Section	Summary	Questions/Comments
	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 fulltime 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 pursuant to the process described in subpart K of part 155.	
	Qualified health plan issuer or QHP issuer means a health insurance issuer that offers, pursuant to a certification from an Exchange, a QHP.	
	Qualified individual means, with respect to an Exchange, an individual who has been determined eligible to enroll in a QHP in the individual market offered through the Exchange.	
	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 means the health insurance market under which individuals obtain health insurance coverage (directly or through any arrangement) on behalf of themselves (and their dependents) through a group health plan maintained by a small employer (as defined in this section).	
	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 by a State		
§155.100-Establishment of a State Exchange	Each state may establish an Exchange that facilitates the purchase of QHPs and provides for the establishment of a SHOP. Exchanges may be governmental agencies (either existing executive branch agencies or independent public agencies) or non-profit entities established by the state.	
§155.105-Approval of a State Exchange	Each State Exchange must be approved by the Secretary of HHS no later than January 1, 2013 in order to begin offering QHPs on January 1, 2014. The regulation interprets the term "fully operational" to mean that an Exchange is capable of beginning operations by October 1, 2013 to support the initial open enrollment period in §155.410.	

Section	Summary	Questions/Comments

	Approval standards:
	• Exchanges must be established consistent with the requirements of the regulation.
	• Exchanges must be capable of carrying out required functions:
	  ○ Minimum Exchange functions
	  ○ Enrollment functions
	  ○ SHOP functions
	  ○ QHP certification functions
	• Exchanges must be capable of complying with information requirements with respect to subsidies, in accordance with rules to be issued later.
	• Exchanges must agree to perform its duties related to the transitional reinsurance program and enter into a contract with one or more reinsurance entities to carry it out.
	• The entire geographic area of the state must be covered by one or more Exchanges.
	
	Approval process:
	• States must submit an Exchange Plan to HHS, which will detail how it will meet each of the approval standards above and include any agreements the State has entered into to carry out Exchange responsibilities. HHS will issue a template outlining the required components of the Exchange Plan.
	• HHS will conduct an operational readiness assessment, which will be coordinated with the ongoing grants monitoring process. Additional guidance on these assessments will be issued at a later date.
	• Each State must receive written approval or conditional approval of its Exchange Plan in order to be approved to operate. The approved Exchange Plan will constitute an agreement between the State and HHS.
	• Because work will be ongoing systems development and contracting work that extends past January 1, 2013, HHS will issue conditional approvals to states that are making progress and will have an Exchange that is operational by January 1, 2014, even if it cannot demonstrate complete readiness on January 1, 2013.
	• HHS is considering establishing a review process for Exchange Plans that is similar to Medicaid and CHIP for which there would be 90 days to review the plan and approve, deny or request comment on the plan.
	HHS is seeking comments on this review process..
	
	Changes to the Exchange Plan
	• A State must notify HHS before making significant changes to its Exchange Plan and must receive written approval of these changes.
	• *HHS is considering utilizing the state plan amendment process that is used for Medicaid and CHIP and is seeking comments on the subject.*	

§155.106-Election to operate an Exchange after 2014	A state that does not have in place an approved or conditionally approved Exchange Plan and operational readiness assessment by January 1, 2013 may seek initial approval to operate an Exchange by following the process and meeting the standards outlined in §155.105 above. The Exchange Plan must be approved or conditionally approved prior to January 1 of the year before the first coverage sold through the Exchange would become effective. States must also work with	

Section	Summary	Questions/Comments
	HHS to develop a transition plan. A State-operated Exchange may cease operations and elect have the Federal government establish an Exchange in the State. The State must provide at least 12 months' notice to HHS prior to ceasing operations and work with HHS to develop and execute a transition plan.	
§155.110-Entities eligible to carry out Exchange functions	Entities with whom the Exchange contracts to carry out one or more responsibilities must: • Be incorporated under and subject to the laws of one or more States; • Have demonstrated experience on a State or regional basis in the individual and small group markets and in benefits coverage; and • Not be a health insurance issuer or be treated as a health insurance issuer. The regulation specifically identifies State Medicaid agencies as entities eligible to contract with the Exchange. *HHS is seeking comments on the extent to which it should impose conflict of interest requirements on contracted entities.* *HHS is seeking comments on how to construct a model for State-Federal partnership for carrying out Exchange responsibilities consistent with* §1311(f)(3) and (d)(5) of the ACA. The Exchange must remain responsible for meeting all Federal requirements related to contracted functions. If the Exchange is established as an independent State agency or as a not-for-profit entity, it must have a clearly-defined governing board and operate under a formal, publicly-adopted operating charter or by-laws. The board must hold regular public meetings. A majority of the board must be free from conflicts of interest. A conflict of interest is defined as representing health insurers, agents, brokers, or other individuals licensed to sell health insurance. States may adopt more stringent or specific conflict of interest policies. *HHS is seeking comments on the extent to which these categories of representatives with potential conflicts of interest should be specified and on the types of representatives who have potential conflicts of interest.* A majority of board members must also 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. *HHS is seeking comment on the types of representatives that should be on Exchange board to ensure that consumer interests are well-represented and that the Exchange board has the necessary technical expertise.* States may establish a separate governance structure for the SHOP Exchange. If it chooses to do so, the two governance entities must coordinate and share data. If a State opts to use a single governance structure for both, it must have adequate resources to assist individuals and small	

Section	Summary	Questions/Comments
	employers. HHS will periodically review the governance of Exchanges. *HHS is requesting comment on the recommended frequency of reviews.*	
§155.120-Non-interference with Federal law and non-discrimination standards	Exchange rules may not conflict with, or prevent the application of, relevant HHS regulations. Nothing in the regulation shall be construed to preempt any state law that does not prevent the application of title I of PPACA. Exchanges may not be operated in any way that discriminates on the basis of race, color, national origin, disability, age, sex, gender identity, or sexual orientation.	
§155.130-Stakeholder consultation	Exchanges must consult, on an ongoing basis, with the following categories of stakeholders: • Educated health care consumers; • Individuals and entities with experience facilitating enrollment in health coverage; • Advocates for enrolling hard-to-reach populations, including those with mental health or substance abuse disorders (HHS also encourages consultation with advocates for individuals with disabilities and those who need culturally and linguistically appropriate services); • Small businesses and self-employed individuals; • State Medicaid and CHIP agencies (HHS also encourages consultation with Medicaid and CHIP beneficiaries); • Federally-recognized tribes within the Exchange's geographic area; • Public health experts; • Health care providers; • Large employers; • Health insurance issuers; and • Agents and brokers. *HHS will provide additional guidance to tribes and States on consultation.*	
§155.140-Establishment of a regional Exchange or subsidiary Exchange	A State may participate in a regional Exchange that spans two or more States, which need not be contiguous. The regional Exchange would submit a single Exchange plan, which will be evaluated and approved using the criteria outlined in §155.105. HHS encourages States to consider the following: • How a regional Exchange would meet the Exchange requirements; • How a regional Exchange would cooperate with State Departments of Insurance; • How to provide a consistent level of consumer protections across the States; • Procedures for State withdrawal from the Exchange; and • Financing of the Exchange. A State may establish multiple subsidiary Exchanges if each serves a distinct geographic area that is at least as large as a geographic rating area described in PHSA §2701(a). *HHS is requesting comments regarding operational or policy concerns raised by subsidiary Exchanges that cover areas across State lines and the extent to which more*	

Section	Summary	Questions/Comments
	flexibility in the structure of subsidiary Exchanges should be allowed. Regional and subsidiary Exchanges must meet all requirements for Exchanges, and perform the functions for a SHOP outlined in the regulations. If a regional or subsidiary Exchange maintains separate governance structures for individual and SHOP Exchanges, the geographic service areas must be identical.	
§155.150-Transition process for existing State health insurance Exchanges	Unless determined to be non-compliant, an Exchange is presumed to be in compliance if: • The Exchange was operating prior to January 1, 2010; and • The State has insured a percentage of its population that is not less than the percentage of the population projected to be covered nationally under PPACA when fully implemented. *HHS is requesting comments regarding how to make this determination. They are proposing to use the year 2016 as the benchmark for full implementation, and are considering different projections of national coverage in this year: CMS Actuary (93.6%) and CBO (95%).* Any state that is currently operating an Exchange that is presumed to be compliant must work with HHS to identify areas of non-compliance.	
§155.160-Financial support for continued operations	A State must develop a plan to ensure its Exchange has sufficient funding to support ongoing operations beginning January 1, 2015. States may fund exchanges through user fees or assessments or by other methods, so long as those methods do not violate other State or Federal laws. Any user fees on health insurance issuers must be announced in advance of the plan year. *HHS is requesting comments on whether it should otherwise limit how and when user fees may be assessed and whether they should be assessed on an annual basis.*	
Subpart C—General Functions of an Exchange		
§155.200-Functions of an Exchange	An Exchange must perform the required functions set forth in subparts E (individual enrollment in QHPs), H (SHOP), and K (QHP certification). An Exchange must grant certifications of exemption from the individual mandate. Standards and eligibility criteria for exemptions will be included in future rulemaking. An Exchange must perform eligibility determinations for enrollment in a QHP, subsidies, Medicaid, CHIP and the Basic Health Plan if one is established by the State. Standards and eligibility criteria for these determinations will be addressed in future rulemaking. Each Exchange must establish a process for appeals of eligibility determinations, which will be addressed in future rulemaking. An Exchange must perform required functions related to oversight and financial integrity requirements in order to comply with PPACA §1313.	

Section	Summary	Questions/Comments
	An 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. These will be addressed in future rulemaking. *HHS encourages States to consider supplemental standards or functionality for their Exchanges and requests comments regarding these and other functions that should be required of Exchanges.*	
§155.205-Required consumer assistance tools and programs of an Exchange	An Exchange must establish a toll-free call center to respond to requests for assistance by consumers. *HHS suggests that Exchanges consider operating the call center outside of normal business hours and adjusting staffing for expected call volumes. HHS believes the call center should be prepared to provide assistance on a broad range of issues, including:* • *Types of QHPs offered in the Exchange* • *Premiums, benefits, cost-sharing, and quality ratings associated with the QHPs offered* • *Categories of assistance available, including:* ○ *Advance payments of premium tax credits* ○ *Cost-sharing reductions* ○ *Medicaid* ○ *CHIP* • *The application process for enrollment in coverage through the Exchange and other programs, such as Medicaid and CHIP* *HHS also suggests that call centers be used as conduits to consumer assistance programs, Navigators, and other State consumer programs, where appropriate.* *HHS is seeking comment on ways to streamline and prevent duplication of effort by the Exchange call center and QHP issuers' customer call centers, but ensure that consumers have a variety of ways to learn about coverage options and receive assistance on other coverage issues.* An Exchange must maintain an Internet web site that: • Presents standardized comparative information on each available QHP, including: ○ Premium and cost-sharing information ○ Summary of benefits and coverage document *This could be made available through a link to the QHP web site, or the Exchange could require documents to be submitted in a manner that supports a searchable format.* ○ Level of coverage provided (bronze, silver, gold, platinum, or catastrophic) ○ Results of enrollee satisfaction surveys ○ Quality ratings ○ Medical loss ratio ○ Transparency of coverage measures ○ Provider directory	

Section	Summary	Questions/Comments
	HHS is requesting comments on the extent to which the Exchange Web site may satisfy the need to provide plan comparison functionality using HealthCare.gov. • Provides meaningful access to information for individuals with limited English proficiency. Web sites must also be accessible to people with disabilities. *This requirement may be met by providing language assistance services, which may include translated information and "tag lines" directing individuals to translated materials and/or telephone numbers to call to reach interpreters for assistance.* • Publishes the following financial information: ○ Average cost of licensing required by the Exchange ○ Any regulatory fees required by the Exchange ○ Any other payments required by the Exchange ○ Administrative costs of the Exchange ○ Monies lost to fraud, waste and abuse • Provides contact information for Navigators and other consumer assistance services • Allows for eligibility determinations pursuant to §155.200(c) of this rule • Allows for enrollment in coverage in QHPs *HHS is considering a Web site requirement that would allow applicants and enrollees to store and access their personal account information and make changes, provided that the Web site complied with standards issued by HHS.* *HHS is also encouraging Exchanges to develop a feature whereby eligibility and enrollment experts, caseworkers, Navigators, agents and brokers, and other application assisters are able to maintain records of individuals they have assisted with the application process. They are requesting comments on this proposal.* An Exchange must establish and make available electronically a calculator to assist individuals in comparing the costs of coverage in available QHPs after the application of subsidies. *HHS is requesting comments on the extent to which States would benefit from a model calculator and suggestions for its design.* An Exchange must provide a consumer assistance function (including but not limited to a Navigator program) that provides assistance services to consumers. *If an Exchange receives complaints of race, color, national origin, disability, age, or sex discrimination, it may refer these individuals to the HHS Office of Civil Rights.* An Exchange must conduct outreach and education activities separate from the implementation of the Navigator program.	
§155.210-Navigator program standards	Exchanges must award grant funds to public or private entities to serve as Navigators. Navigators must: • Be capable of carrying out all required duties	

Section	Summary	Questions/Comments
	• Demonstrate existing relationships, or the ability to readily establish relationships, with employers and employees, consumers (including the uninsured and underinsured), or self-employed individuals likely to be eligible to enroll in QHPs through the Exchange. • Meet any licensing, certification or other standards prescribed by the State or the Exchange, as appropriate • Be free of conflicts of interest during the term as a Navigator *HHS is requesting comments on whether it should propose additional requirements on Exchanges to make determinations regarding conflicts of interest.* The Exchange must select entities from at least two of the following categories to serve as Navigators: • Community and consumer-focused nonprofit groups • Trade, industry and professional associations • Commercial fishing industry organizations, ranching and farming organizations • Chambers of commerce • Unions • Resource partners of the Small Business Administration • Licensed agents and brokers • Other public or private entities that meet the requirements of this section, which may include: ○ Indian tribes , tribal organizations, urban Indian organizations ○ State or local human service agencies *HHS is requesting comments on whether it should require that at least one of the two types of entities include a consumer-focused nonprofit organization, or whether it should require that Navigator grantees reflect a cross-section of stakeholders.* Navigators may not be health insurance issuers or receive any consideration directly or indirectly from any health insurance issuer in connection with the enrollment of individuals or employers in a QHP. *Such consideration includes any:* • *Monetary or non-monetary commission* • *Kick-back* • *Salary* • *Hourly wage* • *Payment made directly or indirectly to the entity or individual from the QHP issuer.* *This provision would not preclude a Navigator from receiving compensation form health insurance issuers in connection with enrolling individuals, small employers or large employers in non-QHPs. HHS is seeking comments on this issue and whether there are ways to manage any potential conflict of interest that might arise.* A Navigator must carry out the following minimum duties:	

Section	Summary	Questions/Comments
	• Maintain expertise in eligibility, enrollment, and program specifications and conduct public education activities to raise public awareness of the Exchange • Provide information and services in a fair and impartial manner, acknowledging other health programs *HHS is considering standards related to the content of information shared, referral strategies, and training requirements to include in grant award conditions and welcomes comments on the topic.* • Facilitate enrollment in QHPs • Provide referrals to any applicable office of health insurance consumer assistance or ombudsman or other appropriate State agency for any enrollee with a grievance, complaint or question regarding their health plan, coverage, or a determination under that plan • Provide information in a manner that is culturally and linguistically appropriate *HHS is seeking comments regarding any specific standards it might issue on the provision of information in a culturally and linguistically appropriate manner.* *The Exchange may require that a Navigator meet additional standards and carry out additional duties as long as they are consistent with the above.* An Exchange may not use Federal funds to support the Navigator program. However, if Navigators are permitted or required to address Medicaid or CHIP administrative functions, and these functions are performed under a contract or agreement that specifies a method for identifying costs attributable to these programs, the Medicaid and CHIP agencies may claim federal funding for a share of these costs. *HHS is considering a requirement that Exchanges ensure that the Navigator program is operational on the first day of the initial open enrollment period (October 1, 2013) and is seeking comments on this requirement.*	
§155.220-Ability of States to permit agents and brokers to assist qualified individuals, qualified employers, or qualified employees enrolling in QHPs	An Exchange may allow agents and brokers to enroll qualified individuals, employers and employees in QHPs and assist them in applying for subsidies. It may also display information regarding agents and brokers on its web site or in other materials. *Some web-based or other entities with experience in health plan enrollment are seeking to assist in QHP enrollment in several ways, including:* • By contracting with an Exchange to perform outreach and enrollment functions; • Acting independently of an Exchange to perform similar outreach and enrollment functions to the Exchange.	

Section	Summary	Questions/Comments
	To the extent that an Exchange contracts with such entities, it would remain responsible for ensuring that statutory and regulatory requirements pertinent to the contracted functions are met. In addition, HHS notes that subsidies are available only through the Exchange. HHS is seeking comments on the functions that such entities could perform, the potential scope of how these entities would interact with the Exchanges and what standards should apply to an entity performing functions in place of, or on behalf of, an Exchange. They also seek comments on the practical implications, costs, and benefits to an Exchange that coordinates with such entities, as well as any security- or privacy-related implications of such an arrangement. Standards in this section do not apply to agents or brokers serving as Navigators, who many not receive any financial compensation from an issuer for helping an individual or employer select a QHP.	
§155.230-General standards for Exchange notices	Any notice sent by an Exchange pursuant to these regulations must be in writing and include: • Contact information for customer service resources; • An explanation of rights to appeal, if applicable; and • A citation to the specific regulation serving as the cause for notice All applications, forms and notices must be provided in plain language and written in a manner that meets the needs of diverse populations by providing meaningful access to limited English proficient individuals and ensuring effective communication for people with disabilities. *HHS is seeking comments regarding whether it should include requirements to provide information about the availability and steps to obtain oral interpretation services, information about the languages in which written materials are available, and the availability of materials in alternate formats for persons with disabilities, as well as other requirements they might consider to provide meaningful access to limited English proficient individuals and to ensure effective communication for people with disabilities.* The Exchange must annually re-evaluate the appropriateness of the applications, forms, and notices and in consultation with HHS when changes are made.	
§155.240-Payment of premiums	In the individual market, an Exchange generally has 3 options with regard to payment of premiums: • Take no part in payment of premiums, so that enrollees pay premiums directly to the QHP issuer; • Facilitate the payment of premiums by creating an electronic "pass-through" without directly retaining any of the payments; or • Establish a payment option where the Exchange collects premiums from enrollees and pays an aggregated sum to the QHP issuers. An Exchange must allow an individual enrolled in a QHP to pay any applicable premium directly to the issuer, if he or she wishes, regardless of the option chosen above. An Exchange may also allow Indian tribes, tribal organizations and urban Indian organizations to pay the QHP premiums on behalf of qualified individuals, subject to terms and conditions established by the Exchange.	

Section	Summary	Questions/Comments
	HHS is seeking comment on whether and how an upfront group payment mechanism similar to what is currently used by some tribes to enroll members in Medicare Part D plans would work in an Exchange. Under this mechanism tribes offer a selection of plans to members from which they may choose, thus limiting their choices. An Exchange must accept payment of an aggregate premium by a qualified employer, pursuant to standards set forth in §155.705(b)(4). An Exchange may facilitate the collection and payment of premiums through electronic means, though it must conform to any standards and protocols required under §155.260 and §155.270 and must ensure the integrity of the financial transactions. *Premium collection by the Exchange does not make it liable for payment.* *HHS seeks comments concerning Exchange flexibility in establishing the premium payment process and what standards would be appropriate for the Federal government to establish in regulations to ensure fiduciary accountability in the case of an Exchange that collects premiums.*	
§155.260-Privacy and security of information	An Exchange must apply appropriate security and privacy protections when collecting, using, disclosing or disposing of personally identifiable information it collects. 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 or trace an individual's identity. The collection, use, and disclosure of personally identifiable information is limited to what is specifically required by: • This section; • Other applicable law; • Subpart E of this regulation (dealing with enrollment of individuals in individual market QHPs); • Standards established in accordance with §155.200(c); or • Section 1942(b) of the [Social Security] Act (dealing with information required for Medicaid and CHIP eligibility determinations). *Exchanges may not collect, use or disclose personally identifiable information if prohibited by another law. HHS invites comments as to whether and how it should restrict the method of disposal in this section as well.* *Each Exchange should conduct analysis of its operations and functions and determine its HIPAA status and must comply with HIPAA privacy requirements if it is a HIPA covered entity. Regardless of this analysis, each Exchange must implement safeguards to ensure that any and all personally identifiable information received, used, stored, transferred, or prepared for disposal by an Exchange is subject to adequate privacy and security protections.* Exchange security standards must be consistent with HIPAA security rules, and must be applied to sub-contractors through contractual requirements.	

Section	Summary	Questions/Comments
	HHS is considering requiring each Exchange to adopt privacy policies that conform to the Fair Information Practice Principles (FIPPs) and requests comments on their appropriateness in this context and the best means to integrate them into the privacy policies and operating procedures of individual Exchanges while allowing for adaptability to each Exchange's structure and operations. The privacy and security policies and procedures of an Exchange must be in writing and available to HHS and must identify any applicable laws that it will need to follow. Contractors and subcontractors must be covered by the same or higher privacy and security policies than are applicable to the Exchange. *HHS is considering a requirement that each Exchange implement some form of authentication procedure for ensuring that all entities interacting with Exchanges are who they claim.* An Exchange must participate in the data matching program with the state Medicaid and CHIP agencies. Data use agreements between the Exchange and these entities must prevent the unauthorized use or disclosure of personally identifiable information and prohibit the Exchange and agencies from seeking information that they do not reasonably expect to use. Exchanges must adopt privacy and security policies and procedures that meet the standards of the Internal Revenue Code that protect the confidentiality of tax returns and tax return information. Any person who knowingly and willfully uses or discloses personally identifiable information in violation of section 1411(g) of PPACA will be subject to civil money penalties of up to $25,000 per disclosure and any other applicable penalties prescribed by law.	
§155.270-Use of standards and protocols for electronic transactions	To the extent an Exchange performs electronic transactions with a HIPAA covered entity, including State Medicaid programs and QHP issuers, the Exchange must use HIPAA standards and operating rules adopted by HHS pursuant to 45 CFR parts 160 and 162. HIT enrollment standards and protocols developed pursuant to PHSA 3021 will be incorporated within Exchange IT systems as required under the Exchange cooperative agreements awarded pursuant to 1311(a) of PPACA.	
Subpart E—Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans		
§155.400-Enrollment of qualified individuals into QHPs	An Exchange 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. The Exchange must send QHP issuers enrollment information on a timely basis and must develop a process by which QHP issuers may acknowledge the receipt of this information. *HHS will be issuing further guidance regarding the timing of transmission of enrollment information to QHP issuers. They encourage real-time processing and*	

Section	Summary	Questions/Comments
	acknowledgement of enrollment and seek comments on whether they should require a specific frequency for enrollment transaction (e.g. real-time or daily, etc.) The Exchange must maintain records of enrollment, submit enrollment information to HHS, and reconcile enrollment files with QHP issuers at least monthly.	
§155.405-Single streamlined application	The Exchange must use a single streamlined application to collect information necessary for QHP enrollment, subsidies, and Medicaid, CHIP and the Basic Health Plan. HHS will create both a paper-based and web-based dynamic application. If the Exchange seeks to use an alternative application, it must be approved by HHS. *HHS seeks comments on whether it should require that applicants not be required to answer questions that are not pertinent to the eligibility and enrollment process.* The Exchange must accept applications from multiple sources, including: • The applicant; • An authorized representative as defined by state law; or • Or someone acting responsibly for the applicant. An individual must be able to file an application online, by telephone, by mail, or in person. *HHS is soliciting comments on the requirement that individuals must be allowed to file an application in person.*	
§155.410-Initial and annual open enrollment periods	Exchanges must adhere to the initial and annual open enrollment periods. Initial and annual open enrollment periods and special enrollment periods are the only times when an Exchange may permit a qualified individual to enroll in a QHP or change QHPs. The initial open enrollment period will be October 1, 2013 through February 28, 2014. *HHS seeks comments on the duration of the initial open enrollment period.* If the Exchange receives an application for coverage on or before December 22, 2013, the Exchange must ensure a coverage effective date of January 1, 2014. Applications received between the 1st and 22nd of any subsequent month must be processed to ensure an effective date of the 1st of the following month. If the Exchange receives an application for coverage between the 23rd and the last day of any month between December 2013 and February 2014, coverage must be effective either the first day of the following month or the first day of the second following month. *The coverage effective date may not be set and enrollment information may not be sent from the Exchange to the QHP until an individual has been determined to be eligible to purchase coverage through the Exchange.* *Coverage in a QHP may only begin on the first day of a month. This was proposed in order to align with a statutory restriction that individuals may only receive subsidies if they are enrolled in a QHP on the first day of the month. HHS is seeking comment as to whether it should consider allowing at least twice-monthly effective dates for coverage or complete flexibility to allow for coverage to being any day for individuals who forgo*	

Section	Summary	Questions/Comments
	subsidies until the first day of the next month. The Exchange must send written notification to enrollees about the annual open enrollment period. *HHS is considering requiring that the notice be sent no later than 30 days before the start of the annual open enrollment period and requiring that it contain specified information, including:* • *The date annual enrollment begins and ends;* • *Where individuals may obtain information about available QHPs, including the Web site, call center and through Navigator assistance; and* • *Other relevant information.* *HHS is seeking comment on whether they should include such requirements.* The annual open enrollment period will be from October 15 through December 7 of each year, starting in October 2014 for coverage beginning January 1, 2015. *HHS considered an alternative annual open enrollment period from November 1 through December 15 of each year. They are seeking comment regarding the proposed and alternative annual open enrollment periods.* 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. *HHS is seeking comment regarding whether they should require Exchanges to automatically enroll individuals who received subsidies and are then disenrolled from a QHP because the QHP is no longer offered if that individual does not make a new QHP selection.* *HHS is also seeking comment on whether they should require automatic enrollment of individuals into new QHPs when there are mergers between issuers or when one QHP offered by an issuer is no longer offered but there are other options available from the same issuer.* *HHS is also seeking comment on how far any automatic enrollment should extend.*	
§155.420-Special enrollment periods	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. For eligible individuals selecting coverage during a special enrollment period, the Exchange must ensure that their effective date of coverage is on the first day of the following month for all QHP selections made by the 22nd of the previous month, and on either the first day of the following month or the first day of the second following month for selections made between the 23rd and last day of the previous month. There is an exemption to this rule in the case of birth, adoption, or placement for adoption, for which coverage must be effective on the date of birth, adoption, or placement for adoption.	

Section	Summary	Questions/Comments
	Special enrollment periods will last for 60 days from the date of the triggering event unless the regulation specifically provides otherwise. All requests for special enrollment periods must be evaluated by the Exchange as part of the eligibility determination process. For purposes of special enrollment periods, a dependent is any individual who is or may become eligible for coverage under the terms of a QHP because of a relationship to an enrollee. Triggering Events: • Loss of other minimum essential coverage, defined as any event that triggers a loss of eligibility for other minimum essential coverage. *Examples would include* ○ *Decertification of a QHP outside of the annual open enrollment period;* ○ *Legal separation or divorce ending eligibility of a spouse or step-child as a dependent;* ○ *End of dependent status;* ○ *Death of an individual enrolled in minimum essential coverage ending eligibility for covered dependents;* ○ *Termination of employment or reduction in the number of hours required to maintain coverage;* ○ *Relocation outside the service area of the QHP.* ○ *Termination of employer contributions for a qualified individual or dependent who has coverage that is not COBRA continuation coverage;* ○ *Exhaustion of COBRA continuation coverage;* ○ *Reaching a lifetime limit on all benefits in a grandfathered plan;* ○ *Termination of Medicaid or CHIP.* *HHS is seeking comment on its limitation of the special enrollment period to only those who lose minimum essential coverage, as opposed to any coverage. This was done to avoid adverse selection.* • Addition of a dependent through marriage, birth, adoption, or placement for adoption; *HHS seeks comments as to whether States might consider expanding the special enrollment period to include gaining dependents through other life events.* • Error in enrollment where the Exchange finds that 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. • QHP in which an individual was enrolled substantially violated a material provision of its contract in relation to such individual and their dependents. *One example would be misrepresentation of the plan while marketing.* • Becoming newly eligible or newly ineligible for premium tax credits or a change in eligibility for cost-sharing reductions. This would allow an individual to newly enroll in	

Section	Summary	Questions/Comments
	coverage or to change from one QHP to another. *HHS seeks comments as to whether the start of the 60 day special enrollment period should be based upon the date on which an individual experiences a change in eligibility or based upon the date of the eligibility determination.* *HHS also requests comments on the timing of the special enrollment period in the case of an individual whose employer-sponsored coverage no longer provides minimum essential benefits or is no longer affordable in the coming plan year. In such a case, the individual would be allowed to apply for QHP coverage while still covered so as to prevent a gap in coverage.* • New QHPs offered through the Exchange become available to an employee as a result of a permanent move. *HHS requests comments on whether the special enrollment period should begin on the date of the permanent move or on the date the individual provides notification of the move.* • Indians will be entitled to a monthly special enrollment period, pursuant to section 1311(c)(6)(D) of PPACA. *HHS solicits comments on the potential implications on the process for verifying Indian status.* • Exceptional circumstances, as determined by the Exchange or HHS. *This special enrollment period could be used for a variety of situations, including natural disasters such as hurricanes or floods. Exceptional circumstances include circumstances that would impede an individual's ability to enroll on a timely basis, through no fault of his or her own.* Loss of coverage does not include failure to pay premiums on a timely basis, including COBRA premiums prior to the expiration of COBRA coverage, or situations allowing for a rescission. During a special enrollment period, an existing enrollee of a QHP may only switch to another plan within the same coverage level. There would be an exception to this rule in the case of an individual who is newly eligible for subsidies. *HHS is requesting comment on whether an exception should also be made in the case of an individual enrolled in a catastrophic plan who becomes pregnant.* *HHS clarifies that the Exchange will provide information, accept applications, perform eligibility determinations, and accept enrollments and send enrollment information to QHPs year round in order to accommodate special enrollment periods and coverage through Medicaid and CHIP.* *To the extent other law applies to require a special enrollment period, that law will continue to apply.*	
§155.430-Termination of coverage	The Exchange must determine the form and manner in which QHP coverage may be terminated. The following events will cause an individual's coverage in a QHP to be terminated: • Voluntary termination by enrolled with appropriate notice to the Exchange;	

Section	Summary	Questions/Comments
	• Loss of eligibility to purchase through the Exchange; • Enrolled becomes covered in other minimum essential coverage; • Payment of premiums for QHP coverage ceases, provided that the grace period in §156.270(d) has elapsed; • Coverage is rescinded; • QHP terminates or is decertified by the Exchange; • Enrolled switches to another QHP during an annual open enrollment period or special enrollment period. An Exchange must establish maintenance of records procedures for terminations of coverage, track the number of individuals for whom coverage has been terminated, and submit that information to HHS on a monthly basis, establish terms for reasonable accommodations, and retain records in order facilitate audit functions. Effective dates of terminations: • In the case of an individual who requests termination, coverage will be terminated effective on the date specified by the enrollee if the Exchange and QHP have a reasonable amount of time. If not, coverage will be terminated effective the first day after a reasonable amount of time has passed. • In the case of an enrollee obtaining new minimum essential coverage, the day before the effective date of the new coverage. *HHS is soliciting comments regarding how Exchanges work with QHP issuers to implement this proposal, which is intended to prevent double coverage (which would make an individual ineligible for subsidies).* • In the case of termination by the Exchange or QHP as a result of the enrollee changing QHPs, the last day of coverage before the new coverage begins. • In the case of any other termination, the last day of coverage is the 14th day of the month if the notice is sent by the Exchange or termination initiated by the QHP by the 14th day of the previous month, or the last day of the month, if the notice sent or termination initiated by the last day of the previous month.	
Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)		
§155.700-Standards for the establishment of a SHOP	An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpar, and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.	
§155.705-Functions of a SHOP	A SHOP must carry out all required functions of an Exchange outlined in subparts C (General Functions), E (Individual Enrollment), H (SHOP Functions), and K (Certification of QHPs), except: • Individual eligibility determinations and appeals of such determinations; • Enrollment of qualified individuals into individual market QHPs; • Premium calculator; *HHS encourages a SHOP to consider options to calculate and display the net employee contribution to the premium for different plans and different family compositions, after any employer contribution has been subtracted from the*	

Section	Summary	Questions/Comments
	full premium amount. • Certification of exemptions from the individual coverage requirement; • Requirements relating to payment of premiums by individuals, Indian tribes, tribal organizations, and urban Indian organizations. In addition, a SHOP must: • Adhere to unique enrollment and eligibility requirements in §155.710 through 730. • Facilitate special enrollment periods under §155.420, except for those due to changes in immigration status and in eligibility for subsidies. • Allow a qualified employer to choose a level of coverage, under which a qualified employee may select an available QHP; ○ Exchanges may also choose additional ways for employers to offer one or more plans to employees, including: ▪ Allowing employees to choose any QHP at any level of coverage; ▪ Allowing employers to select specific levels from which an employee may choose a QHP; ▪ Allowing employers to select specific QHPs from different levels of coverage from which an employee may choose; or ▪ Allowing employers to select a single QHP to offer employees. *HHS requests comments on its interpretation of §1312(a)(2)(A) and (f)(2)(B) of PPACA, which speaks to employer specification of a level of coverage and permit a single QHP selection by an employer, respectively, and on the proposed flexibility in this provision.* *HHS requests comments on whether QHPs offered in the SHOP should be required to waive 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.* • 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. ○ The SHOP must provide a monthly bill to qualified employers that identifies the total premiums owed. ○ The SHOP must collect from employers offering multiple coverage options a single cumulative premium payment for all a qualified employer's qualified employees enrolled through the employer in the SHOP. • Ensure that QHPs meet certification requirements outlined in §156.285. • Require all QHPs to make any changes to rates at a uniform time that is either quarterly, monthly, or annually and require that the rate for a given employer not change during the plan year. *HHS requests comments on whether it should allow a more permissive or restrictive timeframe than monthly, quarterly, or annually and on what rates*	

Section	Summary	Questions/Comments
	should be used to determine premiums during the plan year. • Offer qualified employers and employees only small group QHPs. It may make available only those QHPs that meet the SHOP requirements if the State elects to merge its individual and small group risk pools. • States may allow insurers in the large group market to offer health plans inside of the SHOP beginning in 2017. In states that elect to do so, large employers could make an employee eligible for the SHOP if it provides all full-time employees the opportunity to do so.	
§155.710-Eligibility standards for SHOP	The SHOP must permit qualified employers to purchase coverage for qualified employees in the SHOP. The SHOP must ensure that the employer employs no more than 100 employees, with the exception that a State may limit enrollment in the small group market to employers with no more than 50 employees until January 1, 2016. *Section 1304 of PPACA defines the calculation of an employer's size based upon the average number of employees employed on business days during the preceding calendar year. The terms "employer," small employer," and "large employer" are defined in §155.20 and are based on the definitions in the PHS Act. The PHS act determines employer size by counting all employees, including part-time and seasonal employees, to determine an employer's size. Part time workers would be counted in the same manner as full-time workers, while seasonal employees would be counted proportionately to the number of days they work in a year…Because the PHS Act definition of employer and ERISA definition of group health plan refer to at least 1 employee, they exclude sole proprietors, certain owners of S corporations, and certain relatives of each of the above. HHS solicits comments on this approach.* The SHOP must ensure that a qualified employer provides an offer of coverage through a SHOP to all full-time employees. An employer may cover all employees through the SHOP covering its principal business address or may cover employees through the SHOPs covering each employee's primary worksite. *If an employer opts for the latter coverage option, SHIPs could establish a participation rule with respect to the number of employees employed by the employer within the service area of the SHOP.* An employer participating in SHOP may continue to do so if the number of workers employed grows to exceed 100 (or 50 if the state chooses that level until 2016), provided the employer continues to meet all other eligibility requirements. A qualified employee is an employee who receives an offer of coverage through the SHOP from a qualified employer.	
§155.715-Eligibility determination process for SHOP	A SHOP must determine eligibility of an employer consistent with the standards in §155.710. *SHOPs may allow employers to self-report the size of their workforce with an attestation of its accuracy; however, they may also require a more stringent determination of*	

Section	Summary	Questions/Comments
	employer size. The SHOP must also verify that the employer offers coverage through the SHOP to all full-time employees and that at least one employee works in the SHOP's service area. HHS believes self-reporting with attestations should be sufficient to verify this information. The SHOP must use only 2 application forms, one for employers and one for employees. The SHOP may use information attested to by the employer or employee on the applicable application for determining eligibility. However, the SHOP must verify that each employee applying for coverage is listed on the employer's roster of employees. A SHOP may establish additional verification methods. *Future rulemaking will address appeals related to this process.* The SHOP must have processes to resolve doubts regarding information provided on employer and employee applications. The applicant must be notified by the SHOP and the SHOL must make a reasonable effort to identify and address the cause of the doubt, confirm the accuracy of relevant information and provide the applicant with 30 days to correct the possible error. The applicant must then be notified of the SHOP's determination. If an employer was enrolled in a plan before the completion of the verification process, the SHOP must then discontinue the employer's participation at the end of the month following the month in which the notice was sent. The SHOP must notify employers and employees of eligibility determinations and their rights to appeal. If a qualified employer ceases to provide coverage through the SHOP, the SHOP must ensure that: • Each QHP terminates the coverage of the employers qualified employees; and • Each qualified employee enrolled in a QHP is notified of the employer's withdrawal and their termination of coverage in advance. *HHS is considering whether this notice must inform the employee about eligibility for special enrollment periods in the Exchange and about the eligibility process for subsidies, Medicaid, and CHIP. They solicit comments on this eligibility and notification process.*	
§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. The SHOP must establish a uniform enrollment timeline and process to be followed by all employers and QHPs in the SHOP, which includes the following activities that must occur before the effective date of coverage for qualified employees: • Determination of employer eligibility • Qualified employer selection of QHPs offered to qualified employees • Provision of a specific timeframe for employer selection of level of coverage or QHP offering	

Section	Summary	Questions/Comments
	• Provision of a specific timeframe for employees to complete the employee application process • Determination and verification of employee eligibility for enrollment through the SHOP • Enrollment processing of employees into selected QHPs • Establishment of effective dates of employee coverage. *These activities should be standardized relative to a plan year, rather than a calendar year, to reflect the rolling enrollment of the SHOP.* The SHOP must process applications in accordance with the above timeline and adhere to the requirements in §155.400(b) regarding enrollment and timing of data exchange between the SHOP and QHPs. The SHOP must adhere to standards in §155.705(b) regarding payment administration. The SHOP must ensure that qualified employees are notified of their effective date of coverage. The SHOP must maintain records of qualified employer participation and qualified employee enrollment in the SHOP, which must also be reported to HHS, consistent with §155.400(d). Enrollment reconciliation with QHPs must occur at least monthly, though SHOPs may conduct them more frequently. *HHS welcomes comments about whether it should establish target dates or deadlines so that multi-State qualified employers are subject to consistent rules.* If a qualified employee voluntarily terminates coverage from a QHP, the SHOP must notify the individual's employer.	
§155.725-Enrollment periods under SHOP	The SHOP must adhere to the start of the initial open enrollment period for the Exchange and ensure that enrollment transactions are sent to QHPs and that issuers adhere to coverage effective dates in accordance with §155.260. The initial open enrollment period for SHOP begins on October 1, 2013 for coverage effective January 1, 2014. Because of the rolling enrollment in SHOP, there is no end date for the open enrollment period. Employers may begin participating in SHOP at any time during the year, though qualified employees may only enroll or change plans once a year unless they qualify for a special enrollment period. Plan years inside SHOP must consist of a 12 month period beginning with the employer's effective date of coverage. *HHS invites comments on these provisions.* A SHOP must provide for an annual employer election period in advance of the annual open enrollment period, during which time a qualified employer may modify its contribution and plan offerings. A SHOP must notify participating employers that their annual election period is approaching. *HHS is considering whether to require the employer to receive 30 days advance notice*	

Section	Summary	Questions/Comments
	that the election period is approaching. HHS solicits comments on this requirement. A SHOP must establish an annual employee open enrollment period for qualified employees. This period must occur prior to the end of the plan year and after the employer's election period. *HHS solicits comments on this requirement.* A SHOP must ensure that a qualified employee hired outside of the initial or annual open enrollment period would have a specified window set by SHOP to seek coverage in a QHP beginning with the first day of employment, which would continue through the end of the employer's plan year, at which point the employee could renew or change coverage. *HHS solicits comments on the se proposed notices and their interaction with existing law and regulation.* A SHOP must establish effective dates of coverage for qualified employees consistent with those described in §155.720. A qualified employee enrolled in a QHP through SHOP will remain enrolled in that plan in the next plan year unless: • The employee terminates coverage in accordance with §155.430; • The employee enrolls in another QHP if that option exists; or • The QHP in which the employee was enrolled is no longer available. *HHS welcomes comments about its approach in differentiating individual and small group enrollment as well as specific comments concerning the proposed structure for initial, rolling, and annual open enrollment through SHOP.*	
§155.730-Application standards for SHOP	SHOP applications must adhere to application standards in this section. The SHOP must use a single employer application to determine employer eligibility and to collect the information necessary for an employer to purchase coverage through the SHOP. This information must include the: • Employer's name and address • Number of employees • Employer Identification Number • List of qualified employees and their SSNs. *The application may be submitted by other individuals or organizations on behalf of the employer.* *HHS welcomes comments regarding other employer information it should require a SHOP to collect.* The SHOP must use a single employee application to collect eligibility and QHP selection and enrollment information from employees. *The single streamlined application used in the individual Exchange may be modified to meet the needs of an employee in the SHOP. The application may be submitted by other individuals or organizations on behalf of the employee.*	

Section	Summary	Questions/Comments
	SHOPs may use a model single employer application and model single employee application created by HHS. *The model application will be proposed by HHS, after consultation with the NAIC.* A SHOP may use an alternative employer application with approval from HHS. It should include the information specified above. It may also use an alternative employee application with approval from HHS. The SHOP must allow employers and employees to submit their eligibility and enrollment information consistent with §155.405(c).	
Subpart K—Exchange Functions: Certification of Qualified Health Plans		
§155.1000-Certification standards for QHPs	An Exchange may not make available any health plan that is not a QHP. A QHP must have a certification issued or recognized by the Exchange as QHPs. Any reference to QHPs includes multi-State plans, unless specifically provided for otherwise. The Exchange may certify a health plan as a QHP if it provides evidence that it complies with the minimum certification requirements in subpart C of part 156 and the Exchange determines that making it available is in the interests of qualified individuals and qualified employers in the state. An Exchange may not exclude a plan because: • It is a fee-for-service plan; • Through the imposition of price controls; or • On the basis that it provides treatments necessary to prevent patients' deaths in circumstances the Exchange determines are inappropriate or too costly.	
§155.1010-Certification process for QHPs	The Exchange must establish procedures for the certification of QHPs. A multi-State plan offered through OPM must be deemed as certified by the Exchange. MSPs must meet all the requirements of a QHP, as determined by OPM. *HHS believes the intent of the statute is that each Exchange must accept MSPs as QHPs without applying an additional certification process to such plans.* The Exchange must complete the certification f QHPs prior to the open enrollment periods established in §155.410. The Exchange must monitor QHP issuers for demonstration of ongoing compliance with the certification requirements in §155.1000(c).	
§155.1020-QHP issuer rate and benefit information	An Exchange must receive a QHP issuer's justification for a rate increase prior to its implementation and ensure that the issuer posts it to its website. *The Exchange may satisfy this requirement by receiving it from the state Department of Insurance or HHS.* The Exchange must consider the following factors related to rates before certifying a QHP: • The justification of the increase prior to its implementation; • Recommendations provided to the Exchange by the State under PHSA 2794(b)(1)(B); • Any excess rate growth outside the Exchange compared to rate growth inside the	

Section	Summary	Questions/Comments
	Exchange. *The state rate review process, when available, should be leveraged by the Exchange to avoid any duplication with State law.* *HHS is considering a standard for the final rule in which there would be a bifurcated process for the rate increase justification. Where PHSA section 2794 applies (rates are subject to review), the Exchange may rely on the justification submitted pursuant to that section. Where it does not apply, the Exchange would develop a less burdensome rate justification to satisfy this requirement. HHS would encourage the Exchange and Department of Insurance to collaborate in this process. HHS solicits comments on how best to align PHSA 2794 and PPACA 1311(e)(2).* The Exchange must at least annually receive the following information for each QHP: • Rate information • Covered benefits • Cost-sharing information HHS will provide the form and the manner for the submission of this information.	
§155.1040- Transparency in coverage	Exchanges must require plans seeking certification as QHPs to submit transparency information to the Exchange, HHS and state Insurance commissioner as described in §156.220(a). *HHS is soliciting comments under this proposed rule as part of the process of planning for implementation of PPACA 1311(e)(3)(D)* The Exchange must monitor the use of plain language, consistent with the definition in §155.20 and future guidance to be issued by HHS and Labor, by QHP issuers when making information under this section available. The Exchange must require QHP issuers to make cost sharing information available to enrollees. This is described in §156.220(c).	
§155.1045- Accreditation timeline	The Exchange must establish a consistent deadline for accreditation with respect to each issuer's initial participation in the Exchange. *Although 1311(c0(1)(D)(i) requires QHPs to be accredited, HHS is interpreting the requirement to mean that the issuer must be accredited. §156.275 requires all issuers to be accredited. A grace period may be necessary for issuers that are not already accredited, since the process can take 12-18 months. HHS encourages Exchanges to set timelines that accommodate the length of the process, particularly for issuers seeking accreditation for the first time.*	
§155.1050- Establishment of Exchange network adequacy standards	Each Exchange must ensure that enrollees of QHPs have a sufficient choice of providers. *HHS solicits comments on additional minimum qualitative or quantitative standards for the Exchange to use in evaluating whether the QHP provider networks provide sufficient access to care. In particular, they seek comment on a potential additional requirement that the Exchange establish specific standards under which issuers would be required to maintain the following:* • *Sufficient numbers and types of providers to assure that services are accessible without unreasonable delay;*	

Section	Summary	Questions/Comments
	• *Arrangements to ensure a reasonable proximity of participating providers to the residence or workplace of enrollees, including a reasonable proximity and accessibility of providers accepting new patients;* • *An ongoing monitoring process to ensure sufficiency of the network for enrollees;* • *A process to ensure that an enrollee can obtain a covered benefit from an out-of-network provider at no additional cost if no network provider is accessible for that benefit in a timely manner.* *HHS also seeks comments 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.*	
§155.1055-Service area of a QHP	Exchanges must have a process to establish or evaluate the service areas of QHPs. The service area of a QHP must cover at least a county, or a group of counties if the Exchange designates such a group, unless the issuer demonstrates that serving a partial county is necessary, non-discriminatory, and in the interest of qualified individuals and employers. The Exchange must ensure that QHP service areas are established without regard to the racial, ethnic, language and health status factors outlined in PHSA 2705(a).	
§155.1065-Stand-alone dental plans	The Exchange must allow limited scope stand-alone dental plans to be offered provided that the plan furnishes at least the pediatric essential dental benefit required by PPACA 1302(b)(1)(J). The plan must also comply with IRC 9832(c)(2)(A) and PHSA 2791(c)(2)(A), which define excepted limited scope dental and vision plans. The dental plan may be offered as a stand-alone plan or in conjunction with a QHP. A health plan may be certified as a QHP without offering the pediatric essential dental benefit as long as a stand-alone plan is offered through the Exchange. *HHS is considering interpreting this provision such that an Exchange may require issuers of stand-alone dental plans to comply with any QHP certification requirements and consumer protections that it determines to be relevant and necessary. HHS requests comment on whether some of the requirements on QHP issuers should also apply to stand-alone dental plans as a Federal minimum and what limits Exchanges may face on placing requirement on dental plans, given that they are excepted benefits.* *HHS also requests comment on whether it should set specific operational minimum standards. Substantial operational issues exist with allocating subsidies and calculating actuarial value when stand-alone dental plans segment coverage for the essential health benefits.* *HHS also requests comment on whether QHPs should be required to offer and price dental benefits separately from medical coverage in order to promote comparisons of dental coverage.*	

Section	Summary	Questions/Comments
§155.1075-Recertification of QHPs	The Exchange must implement procedures for the recertification of health plans as QHPs that includes a review of the general certification criteria in §155.1000(c). *An Exchange may use this process to make modifications to any agreements between the Exchange and its QHP issuers. The Exchange may determine the frequency for recertifying QHPs. HHS invites comment as to whether it should specify requirements regarding the term length for recertification.* After reviewing all relevant information and determining whether to recertify a QHP, the Exchange must notify the issuer of its recertification status. If It determines that the QHP should be decertified, it should proceed with the process outlined in §155.1080. The Exchange must complete the recertification process on or before September 15 of each year. *HHS requests comments on the appropriateness of this deadline.*	
§155.1080-Decertification of QHPs	Decertification is the termination by the Exchange of the certification status and offering of a QHP. An Exchange must implement procedures for the decertification of a QWP. The Exchange may decertify a QHP at any time if it determines that the issuer is no longer acting in accordance with the general certification requirements in §155.100(c), including that the QHP participation is no longer in the interest of its enrollees. *HHS recommends that Exchanges solicit input from a broad range of stakeholders, including issuers, when determining how to implement the decertification procedures.* *HHS requests comments on the creation of the process and what other authorities should be extended to the Exchange to make the process more efficient.* The Exchange must establish and appeals process for health plans that have been decertified by the Exchange. If a QHP is decertified, the Exchange must provide notice of the decertification to parties who may be affected, including: • The QHP Issuer; • Exchange enrollees in the QHP who must receive information about a special enrollment period, as described in §155.420; • HHS; and • The State Department of Insurance	
PART 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges		
§156.20-Definitions	"Benefit design standards" means coverage that provides for all of the following: • The essential health benefits as described in section 1302(b) of PPACA • Cost-sharing limits as described in section 1302(c) of PPACA	

Section	Summary	Questions/Comments
	• A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of PPACA, or is a catastrophic plan as described in section 1302(e) of PPACA.	
§156.50-Financial support	Issuers of QHPs, multi-state plans, stand-alone dental plans, and other issuers identified by the exchange that participates in a specific Exchange function that is funded by user fees must remit user fee payments assessed by an Exchange under §155.160.	
Subpart C—Qualified Health Plans Minimum Certification Criteria		
§156.200-QHP issuer participation standards	To participate in an Exchange, a health insurance issuer must have in effect a certificaton iissued 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. A QHP issuer must comply with all requirements of this subpart on an ongoing basis. QHP issuers must comply with any Exchangeprocesses, procedures, and standards set forth under subpart K of part 155 and §155.705 for the small group market. A QHP issuer must ensure that each QHP it offers complies with the benefit design standards defined in §156.20. The levels of coverage that are a component of these benefit design standards will be the subject of future rulemaking. A QHP issuer must be licensed and in good standing in each State in which it iffers health insurance coverage. *HHS interprets the term "good standing" to mean that the issuer has no outstanding sanctions imposed by the Department of Insurance. HHS seeks comments on this interpretation.* A QHP issuer must comply with quality standards established in and pursuant to sections 1311(c)(1), (c)(3), (c)(4), and (g) of PPACA. These requirements will be addressed in future rulemaking. A QHP issuer must adhere to additional proposed requirements, including user fees described in §156.50, if applicable, and the risk adjustment participation requirements in 45 CFR 153. Each QHP issuer must offer at least one QHP in the sliver coverage level and one QHP in the gold coverage level. Any QHP issuer offering a non-catastrophic health plan in the Exchange must offer the identical plan as a child-only health plan, available only to individuals under age 21. A QHP issuer must offer a QHP at the same premium rate consistent with the requirements of §156.255(b). QHP issuers must adhere to the requirements of this subpart and any additional partiipation standards that may be applied by the Exchange or the State. QHP issuers must not discriminate based on race, color, national origin, disability, age, sex, gender identity and sexual orientation.	

Section	Summary	Questions/Comments
§156.210-QHP rate and benefit information	A QHP's rates must be applicable for an entire benefit year or, for the SHOP, plan year as described in §156.285. A QHP issuer must submit rate and benefit information to the Exchange as described in §155.1020(c). A QHP issuer must submit a justification for a rate increase prior to its implementation. *HHS is considering a standard in which issuers will submit a rate justification in the form and manner determined by the Exchange.* QHP issuers must post the rate justifications on their websites. *HHS is considering whether it should develop standards for "prominently posting" rate increase justifications.*	
§156.220-transparency in coverage	In order to receive and maintain certification, issuers must make available to the public and submit to the Exchange, the Secretary of HHS, and the State insurance Commissioner information, including: • Claims payment policies and practices; • Periodic financial disclosures; • Data on enrollment; • Data on disenrollment; • Data on the number of claims that are denied; • Data on rating practices; • Information on enrollee rights under title I of PPACA; • *HHS clarifies that, while the statute refers to "enrollee and participant rights, it believes that its definition of "enrollee" is inclusive of those who may be considered "participants." HHS seeks comment on whether issuers should be required to submit this information to the Exchange and other entities, or to make such information available to the Exchange and other entities.* Issuers must submit the above information in plain language. Use of plain language should be consistent with the definition in §155.20 and future guidance. QHP issuers must make available, in a timely manner through a website or other means, to the enrollee information on cost-sharing responsibilities for a specific service by a participating provider under the enrollee's plan.	
§156.225-Marketing of QHPs	QHP issuers must comply with applciable State laws and regulations regarding marketing by health insurance issuers. QHP issuers may not employ marketing practices that have the effect of discouraging enrollment of individuals with significant health needs. *HHS seeks comment on the best means for an Exchange to monitor QHP issuers' marketing practices to determine whether they have discouraged enrollment of individuals with significant health needs.*	

Section	Summary	Questions/Comments
	HHS seeks comment on also applying a broad prohibition against unfair or deceptive marketing practices by all QHP issuers and their officials, agents or representatives. Such a requirement would protect consumers from deceptive and misleading marketing practices and allow an Exchange to take action to address such practices if the State's Department of Insurance or applicable State agency did not have the authority or capacity to do so under applicable law. *HHS is particularly concerned that QHPs may be marketed towards certain vulnerable populations, such as Medicare beneficiaries, for whom coverage from a QHP would not be necessary.* *They seek comment on a standard that QHP issuers do not misrepresent the benefits, advantages, conditions, exclusions, limitations or terms of a QHP.*	
§156.230-Network adequacy standards	QHP issuers must maintain networks for QHPs that include essential community providers in accordance with §156.235. QHP issuers must maintain networks that comply with any network adequacy standards estalished by the Exchange consistent with §155.1050. QHP issuers must ensure that the provider network of its QHPs is consistent with 2702(c) of PHSA, as amended by PPACA, consistent with PPACA 1311(c)(1)(B). This provision provides an exception to guaranteed issue requirements if the individual lives outside the plan's service area, or if the issuer does not have the capacity to serve the individual because of its existing obligations to enrollees. This exception must be applied uniformly acrossall employees or enrollees without regard toc laims experience or health status. A 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. Issuers must note providers in the directory that are not accepting new patients. *Exchanges will have discretion to determine the best way to get potential enrollees access to provider directories, including through a link to the issue R's website, or by establishing a consoladated provider directory through which a patient may search for providers across QHPs.* *HHS seeks comments on standards it might set to ensure that QHP issuers maintain up-to-date provider directories.*	
§156.235-Essential community providers	QHP issuers must maintain networks that include a sufficient number of essential community providers, where available, that serve low-income, medically underserved individuals. Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedures. *HHS interprets this to mean that while a QHP issuer must contract with essential community providers, coverage of specific services or procedures performed by an essential community provider is not required.*	

Section	Summary	Questions/Comments
	HHS seeks comments on how to define a sufficient number of essential community providers. *HHS is considering whether to provide separate consideration for integrated delivery network health plans where services are provided solely" in-house". They seek comment on whether it should create an exemption for these plans, which could be contingent upon the organization meeting other criteria, such as evidence of services provided to low income populations, compliance with standards for culturally and linguistically appropriate services or implementation of a plan to address health disparities.* Essential community providers are defined to include providers that are eligible for 340B drug pricing. These providers include: • Consolidated Health Centers (FQHC) • AIDS clinics and drug purchasing programs • Black Lung Clinics • Hemophilia Treatment Centers • Urban Indian Clinics • Tribal Centers • Family Planning Clinics • Sexually Transmitted Disease Clinics • Tuberculosis Clinics • Native Hawaiian Health Center • Federally Qualified Health Center look-a-likes • Certain Disproportionate Share Hospitals *HHS solicits comments 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 PHSA section 340B(a)(4).* *HHS notes that there may be a conflict between two provisions of PPACA regarding the payment of essential community providers and FQHCs. 1311(c)(2) provides that nothing shall be construed to requre a QHP to contract with an essential community provider that refuses to accept the generally applicable payment rates of the plan. 1302(g), however, requires that a QHP reimburse FQHCs at each facility's Medicaid prospective payment system rate, which are paid on a per-encounter basis and may be higher than the rates the QHP pays to other providers. HHS invites comment on the issue of FQHC payment.* *HHS seeks comment on establishing requirements regarding reimbursement of Indian health providers. The Indian Health Care Improvement Act allows these providers to recover from third-party payers up to the reasonable charges billed for providing*	

Section	Summary	Questions/Comments
	services, or the highest amount the insurer would pay to other providers, if higher. This requirement applies whether or not there is a contract between the provider and the insurer. HHS believes this requirement applies to QHPs and seeks comment on how it might be reconciled with the essential community provider provision. HHS also seeks comment on other special accomodations that must be made when contracting with Indian health providers, including a possible contract addendum similar to one used by Medicare Part D plans, which would minimize potential disputes and legal challenges when contracting with Indian health providers.	
§156.245-Treatment of direct primary care medical homes	A QHP may provide coverage through a direct primary care medical home that meets requirements to be specified by HHS. *HHS interprets the term "direct primary care medical home plan" to mean an arrangement where a fee is paid by an individual, or on behalf of an individual, directly to a medical home for primary care services, consistent with the program established in Washington state. HHS requests comment on what standards it should establish under this section.*	
§156.250-Health plan applications and notices	QHP issuers must adhere to the standards established for notices in §155.230(b).	
§156.255-Rating variations	A QHP issuer may vary premiums by the rating areas established by the States under PHSA 2701(a)(1)(A). Each QHP issuer must offer a QHP at the same premium rate without regard towhether the plan is offered through an Exchange or whether it is offered directly from the issuer or through an agent. *HHS interprets this provision to mean that an issuer must charge a premium that uses underlying rating assumptions that account for all expected enrollees of a QHP, including individuals who enroll in the QHP outside of the Exchange.* Issuers may vary premiums among no more than 4 different types of family composition: • Individual • Two adults • Adult plus child • Family Issuers must cover all of these categories, but in doing so may combine two or more of them. *HHS seeks comment on how it might structure family rating categories while adhering with PHSA 2701(a)(4), which requres that age and tobacco rating factors may only be applied to the portion of the premium that is attributable to each family member.* *HHS seeks comment on how to structure family rating categories when performing risk adjustment.* *HHS seeks comment on alternatives to four categories for defining family composition.*	

Section	Summary	Questions/Comments
	HHS seeks comment on how to balance the number of categories offered by issuers in order to reduce potential consumer confusion, while maintaining plan offerings and rating structures that are similar to those currently available in the health insurance market. *HHS is considering whether to require QHP issuers to cover an enrollee's tax household, including for purposes of applying individual and family rates because of the potential challenge of administering the premium tax credit for families with non-spousal adult dependents. QHP issuers would not be required to cover dependents outside of the Exchange service area. They seek comment on the potential considerations of this approach.*	
§156.260-Enrollment periods for qualified individuals	QHP issuers must accept and enroll qualified individuals during the initial open enrollment period described in §155.410(b) and during the annual open enrollment period described in §155.410(e). QHP issuers must accept and enroll qualified individuals if they are granted a special enrollment period described in §155.420. QHP issuers must adhere to the coverage effective dates established in §155.410(c), §155.410(f), and §155.420. QHP issuers must provide enrollees with notice of their effective date of coverage corresponding with the effective dates established above.	
§156.265-Enrollment process for qualified individuals	QHP issuers must adhere to the Exchange's process for enrollment in QHPs, which includes standards for the collectiona nd transmission of enrollment information. QHP issuers must use the application adopted pursuant to §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, the QHP issuer must send it to the Exchange, in accordance with the standards in §155.260 and, as applicable §155.270. The issuer may enroll an applicant in a QHP only after it has received a confirmation from the Exchange that the eligibility determination is complete and the applicant is a qualified individual. Issuers must receive enrollment information from the Exchange in a format and manner that is consistent with the standards established pursuant to §155.260 and §155.270. *HHS seeks comment on the frequency with which plans should receive electronic enrollment information.* QHP issuers must abide by the premium payment process established by the Exchange and described in §155.240. QHP issuers must provide enrollees with an enrollment packet. *HHS plans to issue standards for the content of the enrollment information package, which may include an enrollment card, information on how to access care, the summary of benefit and coverage document, and information on how to access the provider*	

Section	Summary	Questions/Comments
	directory and drug formulary. They request comment on the appropriateness of these documents or information that should be included in an enrollment information package. QHP issuers must provide the summary of benefits and coveage document to quailfied indivuals. QHP issuers must reconcile enrollment files with the Exchange no less than once a month, consistent with §155.400(d). QHP issuers must acknowledge the receipt of enrollment information in accordance with Exchange standards established in §155.400(b)(2).	
§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(b). QHP issuers must provide a notice of termination of coverageto the enrollee and the Exchange that is consistent with the standards for effective dates in §155.430(d). *HHS plans to issue standards for the termination of coverage notice, which may incude content such as reason for terminationa nd termination effective date. They solicit comment on other information that should be included in the termination notice.* QHP issuers must develop a uniform policy as permitted by the Exchange for the termination of coverage due to non-payment of premium in accordance with §155.430(b)(2)(iii). QHP issuers must grant a three month grace period for enrollees who receive subsidies through the Exchange and who have paid at least one month's worth of premium. During this period, the issuer must continue to pay all appropriate claims submitted on behalf of the enrollee. If an enrollee is more than one month behind on payments, any payment paid to the QHP issuer will be appied to amounts associated with the first billing cycle in which the enrollee was delinquent. The grace period will reset only when the individual has fully paid all outstanding premiums. During the grace period, the issuer will continue to receive subsidy payments on the delinquent enrollee's behalf from the Treasury. QHP issuers must provide notice to all enrollees who are delinquent on premium payments. *HHS plans to issue standards for content and timing of the notice. They seek comments on the potential required elements of the notice, such as the total amount of delinquent payment, possible date of coverage termination and payment options, and the timing and frequency with which such a notice should be provided to enrollees.* If an enrollee receiving subsidies exhausts the grace period without submitting any premium payment, the issuer may terminate their coverage effective at the completion of the three month period. This termination must be preceded by the appropriate notice as referenced above. QHP issuers must maintain records of termination of coverage in accordance with Exchange standards established in §155.430(c).	

Section	Summary	Questions/Comments
	QHP issuers must abide by effective dates for termination of coverage as described in §155.430(d).	
§156.275-Accreditation of QHP issuers	A QHP issuer must be accredited on the basis of local performance in each of the following categories: • Clinical quality measures, such as HEDIS; • Patient experience ratings on a standardized Consumer Assessment of Healthcare Providers and Systems survey; • Consumer access; • Utilization management; • Quality assurance; • Provider credentialing; • Complaints and appeals; • Network adequacy; and • Patient information programs *HHS clarifies that they interpret "local performance" to mean the performance of the issuer in the State in which it is licensed.* *HHS will provide the standards by which it will recognize accrediting entities in future rulemaking. They seek comments on these standards.* A QHP issuer must authorize the accrediting entity to release certain materials related to the accreditation to the Exchange and HHS. A QHP issuer must obtain its accreditation within the time period established by the Exchange under §155.1045.	
§156.280-Segregation of funds for abortion services	A QHP must comply with any State law that prohibits abortion coverage in QHPs. Nothing in title I of PPACA shall be construed to require a QHP issuer to provide coverage of elective abortion services as part of the essential benefits. If a QHP provides coverage for elective abortion services, the QHP issuer must not use any subsidy funds to pay for those services. It must collect a separate payment from each enrollee equal to the actuarial value of coverage of these services. These payments must be deposited into a separate aggregation account. If QHP premiums are paid through a payroll deposit, the separate payment shall be paid by a separate deposit. A QHP issuer must comply with the efforts or direction of the state health Insurance Commissioner to ensure compliance with this section. A QHP issuer who provides coverage for elective abortion services must provide notice of such to enrollees, only through the summary of benefits and coverage document at the time of enrollment.	

Section	Summary	Questions/Comments
	The above notice, marketing materials, and any information provided by the Exchange and specified by HHS must provide information only with respect for the total combined premium for the QHP. No QHP may discriminate against any individual health care providearmor facility because of its unwillingness to provide, pay for, or refer for abortions.	
§156.285-Additional standards specific to SHOP	A QHP issuer must accept aggregated payment of premiums from the SHOP in accordance with §155.705(b)(4) and must abide by the rate setting timeline established by the SHOP in §155.705(b)(5). QHP issuers must charge the same contract rate for a plan year. QHP issuers must accept and enroll applicants during the rolling initial enrollment period and special enrollment periods for a SHOP established in §155.725 and in §155.420 with the exception of the special enrollment periods for a change in immigration status or a change in subsidy eligibility. QHP issuers must abide by the effective dates of coverage established in §155.410(c). *HHS is considering whether to require QHPs in the SHOP to allow employers to offer dependent coverage. They solicit comment on this potential requirement.* QHP issuers must abide by the SHOP enrollment process and timeline established pursuant to §155.720(b) and accept electronic transmission of enrollment information from the SHOP in accordance with §155.260 and §155.270. Issuers must provide all new enrollees with the enrollment information package as described in §156.265(e) and must provide qualified employers and employees with the summary of cost and coverage document in accordance with §156.265(f). QHP issuers must reconcile enrollment files with the SHOP at least monthly. And abide by the SHOP standards for acknowledgement of the receipt of enrollment information. QHP issuers must issue qualified employees a policy that aligns with the employer's plan year. QHP issuers must abide by the general requirements regarding termination of coverage in §155.270(a) and must provide qualified employers and employees with a notice of termination of coverage of enrollees and QHP non-renewal, as described in §156.270(a) and §156.290(b). If the employer chooses to stop participating in SHOP, a QHP issuer must terminate all enrolled qualified employees.	
§156.290-Non-renewal and decertification of QHPs	A QHP issuer must notify the Exchange of a decision to not seek recertification prior to the beginning of the recertification process adopted by the Exchange pursuant to §155.1075 and must continue covering benefits for each enrollee until the completion of the benefit year or plan year for the SHOP. A QHP issuer must continue providing the Exchange with reporting information for the benefit or plan year even after withdrawing its QHP from the Exchange. The issuer must provide written notice of the non-renewal to each enrollee of the QHP and terminate coverage for enrollees in accordance with the requirements in §156.270.	

Section	Summary	Questions/Comments
	HHS will issue future guidance regarding the timing and content of the notice. They solicit comment on the potential content of the non-renewal notice and any other information they should consider including. If an Exchange decertifies a QHP, the issuer must terminate coverage for the QHP enrollees only after the Exchange has notified them as described in §155.1080 and enrollees have had the opportunity to enroll in other coverage. *HHS seeks comment on the extent to which enrollees should continue to receive coverage from a decertified plan, even if it is for only a short period of time.*	
§156.295-Prescription drug distribution and cost reporting	A QHP issuer must report the following information to HHS in a form and manner to be determined by HHS: • The percentage of all prescriptions that were provided under the contract through retail pharmacies compared to mail order pharmacies • The percentage of prescriptions for which a generic was available and dispensed, broken down by pharmacy type, that is paid by the QHP issuer or PBM under the contract; • The aggregate amount, and the type of rebates, discounts, or price concessions that the PBM negotiates that are attributable to patient utilization under the plan • The aggregate amount of the rebates, discounts, or price concessions that are passed through to the plan sponsor • The total number of prescriptions that were dispensed; and • The 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. *HHS anticipates issuing guidance on these requirements and seeks 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 mail order pharmacy.* *HHS seeks comment on potential definitions for "rebates," "discounts" and "price concessions"; they are considering using the term "direct and indirect remuneration" to encompass these various arrangements.* *HHS interprets statutory references to PBMs to include any entity that performs activities such as prescription drug claims processing, negotiation with prescription drug manufacturers, the development and maintenance of pharmacy networks and the distribution of prescription drugs on behalf of a QHP issuer. They seek comment on this interpretation and whether they should define PBMs as such in this section.* The information reported above is confidential and shall not be disclosed by HHS or by a QHP receiving the information, except that HHS may disclose it in a de-identified format that does not disclose prices paid for prescription drugs in order to report it to GAO or CBO.	

Section	Summary	Questions/Comments
	A QHP issuer that does not provide HHS with the above information or knowingly provides false information the issuer will be subject to a fine that would increase $10,000 for each day the information is not provided or $100,000 for each piece of false information provided.	