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to the date of the planned public forum.

(2) [Reserved]

(d) *Terminations and suspensions.* The Secretary and the Secretary of the Treasury, as applicable, reserve the right to suspend or terminate a section 1332 waiver in whole or in part, at any time before the date of expiration, whenever the Secretary or the Secretary of the Treasury, as applicable, determines that a State has materially failed to comply with the terms of a section 1332 waiver.

(e) *Closeout costs.* If all or part of a section 1332 waiver is terminated or suspended, or if a portion of a section 1332 waiver is withdrawn, Federal funding is limited to normal closeout costs associated with an orderly termination, suspension, or withdrawal, including service costs during any approved transition period, and administrative costs of disenrolling participants.

(f) *Federal evaluators.* (1) A State must fully cooperate with the Secretary, the Secretary of the Treasury, as applicable, or an independent evaluator selected by the Secretary or the Secretary of the Treasury, as applicable, to undertake an independent evaluation of any component of a section 1332 waiver.

(2) As part of this required cooperation, a State must submit all requested data and information to the Secretary, the Secretary of the Treasury, as applicable, or the independent evaluator.

§ 155.1324 State reporting requirements.

(a) *Quarterly reports.* A State must submit quarterly reports to the Secretary in accordance with the terms and conditions of the State's section 1332 waiver. These quarterly reports must include, but are not limited to, reports of any ongoing operational challenges and plans for and results of associated corrective actions.

(b) *Annual reports.* A State must submit an annual report to the Secretary documenting all of the following:

(1) The progress of the section 1332 waiver.

(2) Data on compliance with section 1332(b)(1)(A) through (D) of the Affordable Care Act.

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(3) A summary of the annual post-award public forum, held in accordance with § 155.1320(c), including all public comments received at such forum regarding the progress of the section 1332 waiver and action taken in response to such concerns or comments.

(4) Other information consistent with the State's approved terms and conditions.

(c) *Submitting and publishing annual reports.* A State must submit a draft annual report to the Secretary no later than 90 days after the end of each waiver year, or as specified in the waiver's terms and conditions.

(1) Within 60 days of receipt of comments from the Secretary, a State must submit to the Secretary the final annual report for the waiver year.

(2) The draft and final annual reports are to be published on a State's public web site within 30 days of submission to and approval by the Secretary, respectively.

§ 155.1328 Periodic evaluation requirements.

(a) The Secretary and the Secretary of the Treasury, as applicable, shall periodically evaluate the implementation of a program under a section 1332 waiver consistent with guidance published by the Secretary and the Secretary of the Treasury, as applicable, and any terms and conditions governing the section 1332 waiver.

(b) Each periodic evaluation must include a review of the annual report or reports submitted by the State in accordance with § 155.1324 that relate to the period of time covered by the evaluation.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

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Subpart F—Consumer Operated and Oriented Plan Program

Sec.
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 156.515 CO–OP Standards.
 156.520 Loan terms.

AUTHORITY: Title I of the Affordable Care Act, Sections 1301–1304, 1311–1312, 1321, 1322, 1324, 1334, 1341–1343, and 1401–1402, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18042).

SOURCE: 76 FR 77411, Dec. 13, 2011, unless otherwise noted.

Subpart A—General Provisions

SOURCE: 77 FR 18468, Mar. 27, 2012, unless otherwise noted.

§ 156.10 Basis and scope.

(a) *Basis.* (1) This part is based on the following sections of title I of the Affordable Care Act:

- (i) 1301. QHP defined.
- (ii) 1302. Essential health benefits requirements.
- (iii) 1303. Special rules.
- (iv) 1304. Related definitions.
- (v) 1311. Affordable choices of health benefit plans.
- (vi) 1312. Consumer choice.
- (vii) 1313. Financial integrity.
- (viii) 1321. State flexibility in operation and enforcement of Exchanges and related requirements.
- (ix) 1322. Federal program to assist establishment and operation of non-profit, member-run health insurance issuers.
- (x) 1331. State flexibility to establish Basic Health Programs for low-income individuals not eligible for Medicaid.
- (xi) 1334. Multi-State plans.
- (xii) 1402. Reduced cost-sharing for individuals enrolling in QHPs.
- (xiii) 1411. Procedures for determining eligibility for Exchange participation, advance premium tax credits and reduced cost sharing, and individual responsibility exemptions.
- (xiv) 1412. Advance determination and payment of premium tax credits and cost-sharing reductions.
- (xv) 1413. Streamlining of procedures for enrollment through an Exchange and State, Medicaid, CHIP, and health subsidy programs.

(2) This part is based on section 1150A, Pharmacy Benefit Managers Transparency Requirements, of title I of the Act:

(b) *Scope.* This part establishes standards for QHPs under Exchanges, and addresses other health insurance issuer requirements.

§ 156.20 Definitions.

The following definitions apply to this part, unless the context indicates otherwise:

Applicant has the meaning given to the term in §155.20 of this subchapter.

Benefit design standards means coverage that provides for all of the following:

- (1) The essential health benefits as described in section 1302(b) of the Affordable Care Act;

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(2) Cost-sharing limits as described in section 1302(c) of the Affordable Care Act; and

(3) A bronze, silver, gold, or platinum level of coverage as described in section 1302(d) of the Affordable Care Act, or is a catastrophic plan as described in section 1302(e) of the Affordable Care Act.

Benefit year has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing has the meaning given to the term in §155.20 of this subtitle.

Cost-sharing reductions has the meaning given to the term in §155.20 of this subtitle.

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

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

Health insurance issuer or issuer has the meaning given to the term in §144.103 of this subtitle.

Level of coverage means one of four standardized actuarial values as defined by section 1302(d)(1) of the Affordable Care Act of plan coverage.

Plan year has the meaning given to the term in §155.20 of this subchapter.

Qualified employer has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan has the meaning given to the term in §155.20 of this subchapter.

Qualified health plan issuer has the meaning given to the term in §155.20 of this subchapter.

Qualified individual has the meaning given to the term in §155.20 of this subchapter.

[77 FR 18468, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

§ 156.50 Financial support.

(a) *Definitions.* The following definitions apply for the purposes of this section:

Participating issuer means any issuer offering a plan that participates in the specific function that is funded by user fees. This term may include: health insurance issuers, QHP issuers, issuers of multi-State plans (as defined in §155.1000(a) of this subchapter), issuers of stand-alone dental plans (as described in §155.1065 of this subtitle), or

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other issuers identified by an Exchange.

(b) *Requirement for Exchanges user fees.* A participating issuer must remit user fee payments, or any other payments, charges, or fees, if assessed by the Federally-facilitated Exchange under 31 U.S.C. 9701 or a State-based Exchange under §155.160 of this subchapter.

Subpart B—Standards for Essential Health Benefits, Actuarial Value, and Cost Sharing

SOURCE: 77 FR 42670, July 20, 2012, unless otherwise noted.

§ 156.120 Collection of data from certain issuers to define essential health benefits.

(a) *Definitions.* The following definitions apply to this section, unless the context indicates otherwise:

Health benefits means benefits for medical care, as defined at §144.103 of this chapter, which may be delivered through the purchase of insurance or otherwise.

Health insurance product has the meaning given to the term in §159.110 of this chapter.

Health plan has the meaning given to the term, “Portal Plan” in §159.110 of this chapter.

Small group market has the meaning given to the term in §155.20 of this chapter.

State has the meaning given to the term in §155.20 of this chapter.

Treatment limitations include limits on benefits based on the frequency of treatment, number of visits, days of coverage, or other similar limits on the scope or duration of treatment. Treatment limitations include only quantitative treatment limitations. A permanent exclusion of all benefits for a particular condition or disorder, however, is not a treatment limitation.

(b) *Required information.* The issuers described in paragraph (c) of this section must provide the following information for the health plans described in paragraph (d) of this section in accordance with the standards in paragraph (e) of this section:

(1) Administrative data necessary to identify the health plan;

(2) Data and descriptive information for each plan on the following items:

- (i) All health benefits in the plan;
- (ii) Treatment limitations;
- (iii) Drug coverage; and
- (iv) Enrollment;

(c) *Issuers required to report.* The issuers that offer the three largest health insurance products by enrollment, as of March 31, 2012 (enrollment is determined by HHS based on data submitted in accordance with part 159 of this title) in each state's small group market must provide the information in paragraph (b) of this section.

(d) *Plans affected.* The issuers described in paragraph (c) of this section must provide the information described in paragraph (b) of this section for the health plan with the highest enrollment (as determined by the issuer) within the products described in paragraph (c) of this section.

(e) *Reporting requirement.* To ensure consistency in reporting, an issuer described in paragraph (c) of this section must submit, in a form and manner to be determined by HHS, the information described in paragraph (b) of this section to HHS no later than September 4, 2012.

Subpart C—Qualified Health Plan Minimum Certification Standards

SOURCE: 77 FR 18469, Mar. 27, 2012, unless otherwise noted.

§ 156.200 QHP issuer participation standards.

(a) *General requirement.* In order to participate in an Exchange, a health insurance issuer must have in effect a certification issued or recognized by the Exchange to demonstrate that each health plan it offers in the Exchange is a QHP.

(b) *QHP issuer requirement.* A QHP issuer must—

(1) Comply with the requirements of this subpart with respect to each of its QHPs on an ongoing basis;

(2) Comply with Exchange processes, procedures, and requirements set forth in accordance with subpart K of part 155 and, in the small group market, § 155.705 of this subchapter;

(3) Ensure that each QHP complies with benefit design standards, as defined in § 156.20;

(4) Be licensed and in good standing to offer health insurance coverage in each State in which the issuer offers health insurance coverage;

(5) Implement and report on a quality improvement strategy or strategies consistent with the standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H) and (I) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

(6) Pay any applicable user fees assessed under § 156.50; and

(7) Comply with the standards related to the risk adjustment program under 45 CFR part 153.

(c) *Offering requirements.* A QHP issuer must offer through the Exchange:

(1) At least one QHP in the silver coverage level and at least one QHP in the gold coverage level as described in section 1302(d)(1) of the Affordable Care Act; and,

(2) A child-only plan at the same level of coverage, as described in section 1302(d)(1) of the Affordable Care Act, as any QHP offered through the Exchange to individuals who, as of the beginning of the plan year, have not attained the age of 21.

(d) *State requirements.* A QHP issuer certified by an Exchange must adhere to the requirements of this subpart and any provisions imposed by the Exchange, or a State in connection with its Exchange, that are conditions of participation or certification with respect to each of its QHPs.

(e) *Non-discrimination.* A QHP issuer must not, with respect to its QHP, discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation.

§ 156.210 QHP rate and benefit information.

(a) *General rate requirement.* A QHP issuer must set rates for an entire benefit year, or for the SHOP, plan year.

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(b) *Rate and benefit submission.* A QHP issuer must submit rate and benefit information to the Exchange.

(c) *Rate justification.* A QHP issuer must submit to the Exchange a justification for a rate increase prior to the implementation of the increase. A QHP issuer must prominently post the justification on its Web site.

§ 156.220 Transparency in coverage.

(a) *Required information.* A QHP issuer must provide the following information in accordance with the standards in paragraph (b) of this section:

- (1) Claims payment policies and practices;
- (2) Periodic financial disclosures;
- (3) Data on enrollment;
- (4) Data on disenrollment;
- (5) Data on the number of claims that are denied;
- (6) Data on rating practices;
- (7) Information on cost-sharing and payments with respect to any out-of-network coverage; and
- (8) Information on enrollee rights under title I of the Affordable Care Act.

(b) *Reporting requirement.* A QHP issuer must submit, in an accurate and timely manner, to be determined by HHS, the information described in paragraph (a) of this section to the Exchange, HHS and the State insurance commissioner, and make the information described in paragraph (a) of this section available to the public.

(c) *Use of plain language.* A QHP issuer must make sure that the information submitted under paragraph (b) is provided in plain language as defined under § 155.20 of this subtitle.

(d) *Enrollee cost sharing transparency.* A QHP issuer must make available the amount of enrollee cost sharing under the individual's plan or coverage with respect to the furnishing of a specific item or service by a participating provider in a timely manner upon the request of the individual. At a minimum, such information must be made available to such individual through an Internet Web site and such other means for individuals without access to the Internet.

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§ 156.225 Marketing and Benefit Design of QHPs.

A QHP issuer and its officials, employees, agents and representatives must—

(a) *State law applies.* Comply with any applicable State laws and regulations regarding marketing by health insurance issuers; and

(b) *Non-discrimination.* Not employ marketing practices or benefit designs that will have the effect of discouraging the enrollment of individuals with significant health needs in QHPs.

§ 156.230 Network adequacy standards.

(a) *General requirement.* A QHP issuer must ensure that the provider network of each of its QHPs, as available to all enrollees, meets the following standards—

(1) Includes essential community providers in accordance with § 156.235;

(2) Maintains a network that is sufficient in number and types of providers, including providers that specialize in mental health and substance abuse services, to assure that all services will be accessible without unreasonable delay; and,

(3) Is consistent with the network adequacy provisions of section 2702(c) of the PHS Act.

(b) *Access to provider directory.* A QHP issuer must make its provider directory for a QHP available to the Exchange for publication online in accordance with guidance from the Exchange and to potential enrollees in hard copy upon request. In the provider directory, a QHP issuer must identify providers that are not accepting new patients.

§ 156.235 Essential community providers.

(a) *General requirement.* (1) A QHP issuer must have a sufficient number and geographic distribution of essential community providers, where available, to ensure reasonable and timely access to a broad range of such providers for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(2) A QHP issuer that provides a majority of covered professional services

through physicians employed by the issuer or through a single contracted medical group may instead comply with the alternate standard described in paragraph (b) of this section.

(3) Nothing in this requirement shall be construed to require any QHP to provide coverage for any specific medical procedure provided by the essential community provider.

(b) *Alternate standard.* A QHP issuer described in paragraph (a)(2) of this section must have a sufficient number and geographic distribution of employed providers and hospital facilities, or providers of its contracted medical group and hospital facilities to ensure reasonable and timely access for low-income, medically underserved individuals in the QHP's service area, in accordance with the Exchange's network adequacy standards.

(c) *Definition.* Essential community providers are providers that serve predominantly low-income, medically underserved individuals, including providers that meet the criteria of paragraph (c)(1) or (2) of this section, and providers that met the criteria under paragraph (c)(1) or (2) of this section on the publication date of this regulation unless the provider lost its status under paragraph (c)(1) or (2) of this section thereafter as a result of violating Federal law:

(1) Health care providers defined in section 340B(a)(4) of the PHS Act; and

(2) Providers described in section 1927(c)(1)(D)(i)(IV) of the Act as set forth by section 221 of Public Law 111-8.

(d) *Payment rates.* Nothing in paragraph (a) of this section shall be construed to require a QHP issuer to contract with an essential community provider if such provider refuses to accept the generally applicable payment rates of such issuer.

(e) *Payment of federally-qualified health centers.* If an item or service covered by a QHP is provided by a federally-qualified health center (as defined in section 1905(l)(2)(B) of the Act) to an enrollee of a QHP, the QHP issuer must pay the federally-qualified health center for the item or service an amount that is not less than the amount of payment that would have been paid to the center under section 1902(bb) of the

Act for such item or service. Nothing in this paragraph (e) would preclude a QHP issuer and federally-qualified health center from mutually agreeing upon payment rates other than those that would have been paid to the center under section 1902(bb) of the Act, as long as such mutually agreed upon rates are at least equal to the generally applicable payment rates of the issuer indicated in paragraph (d) of this section.

§ 156.245 Treatment of direct primary care medical homes.

A QHP issuer may provide coverage through a direct primary care medical home that meets criteria established by HHS, so long as the QHP meets all requirements that are otherwise applicable and the services covered by the direct primary care medical home are coordinated with the QHP issuer.

§ 156.250 Health plan applications and notices.

QHP issuers must provide all applications and notices to enrollees in accordance with the standards described in § 155.230(b) of this subtitle.

§ 156.255 Rating variations.

(a) *Rating areas.* A QHP issuer, including an issuer of a multi-State plan, may vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS Act.

(b) *Same premium rates.* A QHP issuer must charge the same premium rate without regard to whether the plan is offered through an Exchange, or whether the plan is offered directly from the issuer or through an agent.

§ 156.260 Enrollment periods for qualified individuals.

(a) *Individual market requirement.* A QHP issuer must:

(1) Enroll a qualified individual during the initial and annual open enrollment periods described in § 155.410(b) and (e) of this subchapter, and abide by the effective dates of coverage established by the Exchange in accordance with § 155.410(c) and (f) of this subchapter; and

(2) Make available, at a minimum, special enrollment periods described in § 155.420(d) of this subchapter, for QHPs

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and abide by the effective dates of coverage established by the Exchange in accordance with § 155.420(b) of this subchapter.

(b) *Notification of effective date.* A QHP issuer must notify a qualified individual of his or her effective date of coverage.

§ 156.265 Enrollment process for qualified individuals.

(a) *General requirement.* A QHP issuer must process enrollment in accordance with this section.

(b) *Enrollment through the Exchange for the individual market.* (1) A QHP issuer must enroll a qualified individual only if the Exchange—

(i) Notifies the QHP issuer that the individual is a qualified individual; and

(ii) Transmits information to the QHP issuer as provided in § 155.400(a) of this subchapter.

(2) If an applicant initiates enrollment directly with the QHP issuer for enrollment through the Exchange, the QHP issuer must either—

(i) Direct the individual to file an application with the Exchange in accordance with § 155.310, or

(ii) Ensure the applicant received an eligibility determination for coverage through the Exchange through the Exchange Internet Web site.

(c) *Acceptance of enrollment information.* A QHP issuer must accept enrollment information consistent with the privacy and security requirements established by the Exchange in accordance with § 155.260 and in an electronic format that is consistent with § 155.270.

(d) *Premium payment.* A QHP issuer must follow the premium payment process established by the Exchange in accordance with § 155.240.

(e) *Enrollment information package.* A QHP issuer must provide new enrollees an enrollment information package that is compliant with accessibility and readability standards established in § 155.230(b).

(f) *Enrollment reconciliation.* A QHP issuer must reconcile enrollment files with the Exchange no less than once a month in accordance with § 155.400(d).

(g) *Enrollment acknowledgement.* A QHP issuer must acknowledge receipt of enrollment information transmitted from the Exchange in accordance with

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Exchange standards established in accordance with § 155.400(b)(2) of this subchapter.

§ 156.270 Termination of coverage for qualified individuals.

(a) *General requirement.* A QHP issuer may only terminate coverage as permitted by the Exchange in accordance with § 155.430(b) of this subchapter.

(b) *Termination of coverage notice requirement.* If an enrollee's coverage in a QHP is terminated for any reason, the QHP issuer must:

(1) Provide the enrollee with a notice of termination of coverage that includes the reason for termination at least 30 days prior to the last day of coverage, consistent with the effective date established by the Exchange in accordance with § 155.430(d) of this subchapter.

(2) Notify the Exchange of the termination effective date and reason for termination.

(c) *Termination of coverage due to non-payment of premium.* A QHP issuer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium as permitted by the Exchange in § 155.430(b)(2)(ii) of this subchapter. This policy for the termination of coverage:

(1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and

(2) Must be applied uniformly to enrollees in similar circumstances.

(d) *Grace period for recipients of advance payments of the premium tax credit.* A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must:

(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

(2) Notify HHS of such non-payment; and,

(3) Notify providers of the possibility for denied claims when an enrollee is in

the second and third months of the grace period.

(e) *Advance payments of the premium tax credit.* For the 3-month grace period described in paragraph (d) of this section, a QHP issuer must:

(1) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the Department of the Treasury.

(2) Return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as described in paragraph (g) of this section.

(f) *Notice of non-payment of premiums.* If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency.

(g) *Exhaustion of grace period.* If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in §155.430(d)(4) of this subchapter, provided that the QHP issuer meets the notice requirement specified in paragraph (b) of this section.

(h) *Records of termination of coverage.* QHP issuers must maintain records in accordance with Exchange standards established in accordance with §155.430(c) of this subchapter.

(i) *Effective date of termination of coverage.* QHP issuers must abide by the termination of coverage effective dates described in §155.430(d) of this subchapter.

§ 156.275 Accreditation of QHP issuers.

(a) *General requirement.* A QHP issuer must:

(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;

(ii) Patient experience ratings on a standardized CAHPS survey;

(iii) Consumer access;

(iv) Utilization management;

(v) Quality assurance;

(vi) Provider credentialing;

(vii) Complaints and appeals;

(viii) Network adequacy and access; and

(ix) Patient information programs, and

(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with §155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

(c) *Accreditation*—(1) *Recognition of accrediting entity by HHS.* Effective upon completion of conditions listed in paragraphs (c)(2), (c)(3), and (c)(4) of this section, at which time HHS will notify the public in the FEDERAL REGISTER, the National Committee for Quality Assurance (NCQA) and URAC are recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirement of this section.

(2)(i) *Scope of accreditation.* Subject to paragraphs (c)(2)(ii), (iii), and (iv) of this section, recognized accrediting entities must provide accreditation within the categories identified in paragraphs (a)(1) of this section.

(ii) *Clinical quality measures.* Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that:

(A) Spans a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care.

(B) Includes measures that are applicable to adults and measures that are applicable to children.

(C) Aligns with the priorities of the National Strategy for Quality Improvement in Health Care issued by the Secretary of HHS and submitted to Congress on March 12, 2011;

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(D) Only includes measures that are either developed or adopted by a voluntary consensus standards setting body (such as those described in the National Technology and Transfer Advancement Act of 1995 (NTTAA) and Office of Management and Budget (OMB) Circular A-119 (1998)) or, where appropriate endorsed measures are unavailable, are in common use for health plan quality measurement and meet health plan industry standards; and

(E) Is evidence-based.

(iii) *Level of accreditation.* Recognized accrediting entities must provide accreditation at the Exchange product type level unless the product type level of accreditation is not methodologically sound. In such cases, the recognized accrediting entity must demonstrate that the Exchange product type level accreditation is not methodologically sound as a condition of the Exchange granting an exception to authorize accreditation at an aggregated level.

(iv) *Network adequacy.* The network adequacy standards for accreditation used by the recognized accrediting entities must, at a minimum, be consistent with the general requirements for network adequacy for QHP issuers codified in § 156.230(a)(2) and (a)(3).

(3) *Methodological and scoring criteria for accreditation.* Recognized accrediting entities must use transparent and rigorous methodological and scoring criteria.

(4) *Documentation.* An accrediting entity must provide the following documentation:

(i) To be recognized, an accrediting entity must provide current accreditation standards and requirements, processes, and measure specifications for performance measures to demonstrate that each entity meets the conditions described in paragraphs (c)(2), and (c)(3) of this section to HHS within 60 days of the publication date of this final rule.

(ii) Recognized accrediting entities must provide to HHS any proposed changes or updates to the accreditation standards and requirements, processes, and measure specifications for performance measures with 60 days notice prior to public notification.

(5) *Data sharing requirements between the recognized accrediting entities and Exchanges.* When authorized by an accredited QHP issuer pursuant to paragraph (a)(2) of this section, recognized accrediting entities must provide the following QHP issuer's accreditation survey data elements to the Exchange, other than personally identifiable information (as described in OMB Memorandum M-07-16), in which the issuer plans to operate one or more QHPs during the annual certification period or as changes occur to these data throughout the coverage year—the name, address, Health Insurance Oversight System (HIOS) issuer identifier, and unique accreditation identifier(s) of the QHP issuer and its accredited product line(s) and type(s) which have been released; and for each accredited product type:

- (i) HIOS product identifier (if applicable);
- (ii) Accreditation status, survey type, or level (if applicable);
- (iii) Accreditation score;
- (iv) Expiration date of accreditation; and
- (v) Clinical quality measure results and adult and child CAHPS measure survey results (and corresponding expiration dates of these data) at the level specified by the Exchange.

[77 FR 18469, Mar. 27, 2012, as amended at 77 FR 42671, July 20, 2012]

§ 156.280 Segregation of funds for abortion services.

(a) *State opt-out of abortion coverage.* A QHP issuer must comply with a State law that prohibits abortion coverage in QHPs.

(b) *Termination of opt out.* A QHP issuer may provide coverage of abortion services through the Exchange in a State described in paragraph (a) of this section if the State repeals such law.

(c) *Voluntary choice of coverage of abortion services.* Notwithstanding any other provision of title I of the Affordable Care Act (or any other amendment made under that title):

(1) Nothing in title I of the Affordable Care Act (or any amendments by that title) shall be construed to require a QHP issuer to provide coverage of services described in paragraph (d) of

this section as part of its essential health benefits, as described in section 1302(b) of the Affordable Care Act, for any plan year.

(2) Subject to paragraphs (a) and (b) of this section, the QHP issuer must determine whether or not the QHP provides coverage of services described in paragraph (d) of this section as part of such benefits for the plan year.

(d) *Abortion services*—(1) *Abortions for which public funding is prohibited.* The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is not permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(2) *Abortions for which public funding is allowed.* The services described in this paragraph are abortion services for which the expenditure of Federal funds appropriated for HHS is permitted, based on the law in effect 6 months before the beginning of the plan year involved.

(e) *Prohibition on the use of Federal funds.* (1) If a QHP provides coverage of services described in paragraph (d)(1) of this section, the QHP issuer must not use any amount attributable to any of the following for the purposes of paying for such services:

(i) The credit under section 36B of the Code and the amount (if any) of the advance payment of the credit under section 1412 of the Affordable Care Act;

(ii) Any cost-sharing reduction under section 1402 of the Affordable Care Act and the amount (if any) of the advance payments of the reduction under section 1412 of the Affordable Care Act.

(2) *Establishment of allocation accounts.* In the case of a QHP to which paragraph (e)(1) of this section applies, the QHP issuer must:

(i) Collect from each enrollee in the QHP (without regard to the enrollee's age, sex, or family status) a separate payment for each of the following:

(A) An amount equal to the portion of the premium to be paid directly by the enrollee for coverage under the QHP of services other than services described in (d)(1) of this section (after reductions for credits and cost-sharing reductions described in paragraph (e)(1) of this section); and

(B) An amount equal to the actuarial value of the coverage of services described in paragraph (d)(1) of this section.

(ii) Deposit all such separate payments into separate allocation accounts as provided in paragraph (e)(3) of this section. In the case of an enrollee whose premium for coverage under the QHP is paid through employee payroll deposit, the separate payments required under this subparagraph shall each be paid by a separate deposit.

(3) *Segregation of funds.* (i) The QHP issuer to which paragraph (e)(1) of this section applies must establish allocation accounts described in paragraph (e)(3)(ii) of this section for enrollees receiving the amounts described in paragraph (e)(1) of this section.

(ii) *Allocation accounts.* The QHP issuer to which paragraph (e)(1) of this section applies must deposit:

(A) All payments described in paragraph (e)(2)(i)(A) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services other than the services described in paragraph (d)(1) of this section;

(B) All payments described in paragraph (e)(2)(i)(B) of this section into a separate account that consists solely of such payments and that is used exclusively to pay for services described in paragraph (d)(1) of this section.

(4) *Actuarial value.* The QHP issuer must estimate the basic per enrollee, per month cost, determined on an average actuarial basis, for including coverage under the QHP of services described in paragraph (d)(1) of this section. In making such an estimate, the QHP issuer:

(i) May take into account the impact on overall costs of the inclusion of such coverage, but may not take into account any cost reduction estimated to result from such services, including prenatal care, delivery, or postnatal care;

(ii) Must estimate such costs as if such coverage were included for the entire population covered; and

(iii) May not estimate such a cost at less than one dollar per enrollee, per month.

(5) *Ensuring compliance with segregation requirements.* (i) Subject to paragraph (e)(5)(iv) of this section, the QHP issuer must comply with the efforts or direction of the State health insurance commissioner to ensure compliance with this section through the segregation of QHP funds in accordance with applicable provisions of generally accepted accounting requirements, circulars on funds management of the Office of Management and Budget and guidance on accounting of the Government Accountability Office.

(ii) Each QHP issuer that participates in an Exchange and offers coverage for services described in paragraph (d)(1) of this section should, as a condition of participating in an Exchange, submit a plan that details its process and methodology for meeting the requirements of section 1303(b)(2)(C), (D), and (E) (hereinafter, “segregation plan”) to the State health insurance commissioner. The segregation plan should describe the QHP issuer’s financial accounting systems, including appropriate accounting documentation and internal controls, that would ensure the segregation of funds required by section 1303(b)(2)(C), (D), and (E), and should include:

(A) The financial accounting systems, including accounting documentation and internal controls, that would ensure the appropriate segregation of payments received for coverage of services described in paragraph (d)(1) of this section from those received for coverage of all other services;

(B) The financial accounting systems, including accounting documentation and internal controls, that would ensure that all expenditures for services described in paragraph (d)(1) of this section are reimbursed from the appropriate account; and

(C) An explanation of how the QHP issuer’s systems, accounting documentation, and controls meet the requirements for segregation accounts under the law.

(iii) Each QHP issuer participating in the Exchange must provide to the State insurance commissioner an annual assurance statement attesting that the plan has complied with section 1303 of the Affordable Care Act and applicable regulations.

(iv) Nothing in this clause shall prohibit the right of an individual or QHP issuer to appeal such action in courts of competent jurisdiction.

(f) *Rules relating to notice.* (1) *Notice.* A QHP that provides for coverage of services in paragraph (d)(1) of this section, must provide a notice to enrollees, only as part of the summary of benefits and coverage explanation, at the time of enrollment, of such coverage.

(2) *Rules relating to payments.* The notice described in paragraph (f)(1) of this section, any advertising used by the QHP issuer with respect to the QHP, any information provided by the Exchange, and any other information specified by HHS must provide information only with respect to the total amount of the combined payments for services described in paragraph (d)(1) of this section and other services covered by the QHP.

(g) *No discrimination on basis of provision of abortion.* No QHP offered through an Exchange may discriminate against any individual health care provider or health care facility because of its unwillingness to provide, pay for, provide coverage of, or refer for abortions.

(h) *Application of State and Federal laws regarding abortions.* (1) *No preemption of State laws regarding abortion.* Nothing in the Affordable Care Act shall be construed to preempt or otherwise have any effect on State laws regarding the prohibition of (or requirement of) coverage, funding, or procedural requirements on abortions, including parental notification or consent for the performance of an abortion on a minor.

(2) *No effect on Federal laws regarding abortion.* Nothing in the Affordable Care Act shall be construed to have any effect on Federal laws regarding:

(i) Conscience protection;

(ii) Willingness or refusal to provide abortion; and

(iii) Discrimination on the basis of the willingness or refusal to provide, pay for, cover, or refer for abortion or to provide or participate in training to provide abortion.

(3) *No effect on Federal civil rights law.* Nothing in section 1303(c) of the Affordable Care Act shall alter the rights and

obligations of employees and employers under Title VII of the Civil Rights Act of 1964.

(i) *Application of emergency services laws.* Nothing in the Affordable Care Act shall be construed to relieve any health care provider from providing emergency services as required by State or Federal law, including section 1867 of the Act (popularly known as “EMTALA”).

§ 156.285 Additional standards specific to SHOP.

(a) *SHOP rating and premium payment requirements.* QHP issuers offering a QHP through a SHOP must:

(1) Accept payment from the SHOP on behalf of a qualified employer or an enrollee in accordance with § 155.705(b)(4) of this subchapter;

(2) Adhere to the SHOP timeline for rate setting as established in § 155.705(b)(6) of this subchapter; and

(3) Charge the same contract rate for a plan year.

(b) *Enrollment periods for the SHOP.* QHP issuers offering a QHP through the SHOP must:

(1) Enroll a qualified employee in accordance with the qualified employer’s annual employee open enrollment period described in § 155.725 of this subchapter;

(2) Provide special enrollment periods described in § 155.420 excluding paragraphs (d)(3) and (6);

(3) Provide an enrollment period for an employee who becomes a qualified employee outside of the initial or annual open enrollment period as described in § 155.725(g) of this subchapter; and

(4) Adhere to effective dates of coverage in accordance with § 156.260 and those established through § 155.720 of this subchapter.

(c) *Enrollment process for the SHOP.* A QHP issuer offering a QHP through the SHOP must:

(1) Adhere to the enrollment timeline and process for the SHOP as described in § 155.720(b) of this subchapter;

(2) Receive enrollment information in an electronic format, in accordance with the requirements in §§ 155.260 and 155.270 of this subchapter, from the SHOP as described in § 155.720(c);

(3) Provide new enrollees with the enrollment information package as described in § 156.265(e);

(4) Reconcile enrollment files with the SHOP at least monthly;

(5) Acknowledge receipt of enrollment information in accordance with SHOP standards; and

(6) Enroll all qualified employees consistent with the plan year of the applicable qualified employer.

(d) *Termination of coverage in the SHOP.* QHP issuers offering a QHP through the SHOP must:

(1) Comply with the following requirements with respect to coverage termination of enrollees in the SHOP:

(i) General requirements regarding termination of coverage established in § 156.270(a);

(ii) Requirements for notices to be provided to enrollees and qualified employers in § 156.270(b) and § 156.290(b); and

(iii) Requirements regarding termination of coverage effective dates as set forth in § 156.270(i).

(2) If a qualified employer chooses to withdraw from participation in the SHOP, the QHP issuer must terminate coverage for all enrollees of the withdrawing qualified employer.

(e) *Participation rules.* QHP issuers offering a QHP through the SHOP may impose group participation rules for the offering of health insurance coverage in connection with a QHP only if and to the extent authorized by the SHOP in accordance with § 155.705 of this subchapter.

§ 156.290 Non-renewal and decertification of QHPs.

(a) *Non-renewal of recertification.* If a QHP issuer elects not to seek recertification with the Exchange, the QHP issuer, at a minimum, must—

(1) Notify the Exchange of its decision prior to the beginning of the recertification process and procedures adopted by the Exchange in accordance with § 155.1075 of this subchapter;

(2) Fulfill its obligation to cover benefits for each enrollee through the end of the plan or benefit year;

(3) Fulfill data reporting obligations from the last plan or benefit year of the certification;

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(4) Provide notice to enrollees as described in paragraph (b) of this section; and

(5) Terminate coverage for enrollees in the QHP in accordance with §156.270, as applicable.

(b) *Notice of QHP non-renewal.* If a QHP issuer elects not to seek recertification with the Exchange for its QHP, the QHP issuer must provide written notice to each enrollee.

(c) *Decertification.* If a QHP is decertified by the Exchange, the QHP issuer must terminate coverage for enrollees only after:

(1) The Exchange has made notification as described in §155.1080 of this subchapter; and

(2) Enrollees have an opportunity to enroll in other coverage.

§ 156.295 Prescription drug distribution and cost reporting.

(a) *General requirement.* In a form, manner, and at such times specified by HHS, a QHP issuer must provide to HHS the following information:

(1) The percentage of all prescriptions that were provided under the QHP through retail pharmacies compared to mail order pharmacies, and the percentage of prescriptions for which a generic drug was available and dispensed compared to all drugs dispensed, broken down by pharmacy type, which includes an independent pharmacy, supermarket pharmacy, or mass merchandiser pharmacy that is licensed as a pharmacy by the State and that dispenses medication to the general public, that is paid by the QHP issuer or the QHP issuer's contracted PBM;

(2) The aggregate amount, and the type of rebates, discounts or price concessions (excluding bona fide service fees) that the QHP issuer or its contracted PBM negotiates that are attributable to patient utilization under the QHP, and the aggregate amount of the rebates, discounts, or price concessions that are passed through to the QHP issuer, and the total number of prescriptions that were dispensed.

(i) Bona fide service fees means fees paid by a manufacturer to an entity that represent fair market value for a bona fide, itemized service actually performed on behalf of the manufac-

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turer that the manufacturer would otherwise perform (or contract for) in the absence of the service arrangement, and that are not passed on in whole or in part to a client or customer of an entity, whether or not the entity takes title to the drug.

(ii) [Reserved]

(3) The aggregate amount of the difference between the amount the QHP issuer pays its contracted PBM and the amounts that the PBM pays retail pharmacies, and mail order pharmacies, and the total number of prescriptions that were dispensed.

(b) *Confidentiality.* Information disclosed by a QHP issuer or a PBM under this section is confidential and shall not be disclosed by HHS or by a QHP receiving the information, except that HHS may disclose the information in a form which does not disclose the identity of a specific PBM, QHP, or prices charged for drugs, for the following purposes:

(1) As HHS determines to be necessary to carry out section 1150A or part D of title XVIII of the Act;

(2) To permit the Comptroller General to review the information provided;

(3) To permit the Director of the Congressional Budget Office to review the information provided; or

(4) To States to carry out section 1311 of the Affordable Care Act.

(c) *Penalties.* A QHP issuer that fails to report the information described in paragraph (a) of this section to HHS on a timely basis or knowingly provides false information will be subject to the provisions of subsection (b)(3)(C) of section 1927 of the Act.

Subparts D–E [Reserved]

Subpart F—Consumer Operated and Oriented Plan Program

§ 156.500 Basis and scope.

This subpart implements section 1322 of the Affordable Care Act by establishing the Consumer Operated and Oriented Plan (CO-OP) program to foster the creation of new consumer-governed, private, nonprofit health insurance issuers, known as “CO-OPs.” Under this program, loans are awarded to encourage the development of CO-

OPs. Applicants that meet the eligibility standards of the CO-OP program may apply to receive loans to help fund start-up costs and meet the solvency requirements of States in which the applicant seeks to be licensed to issue CO-OP qualified health plans. This subpart sets forth the eligibility and governance requirements for the CO-OP program, CO-OP standards, and the terms for loans awarded under the CO-OP program.

§ 156.505 Definitions.

The following definitions apply to this subpart:

Applicant means an entity eligible to apply for a loan described in §156.520 of this subpart.

Consumer operated and oriented plan (CO-OP) means a loan recipient that satisfies the standards in section 1322(c) of the Affordable Care Act and §156.515 of this subpart within the timeframes specified in this subpart.

CO-OP qualified health plan means a health plan that has in effect a certification that it meets the standards described in subpart C of this part, except that the plan can be deemed certified by CMS or an entity designated by CMS as described in §156.520(e).

Exchange has the meaning given to the term in §155.20 of this subchapter.

Formation board means the initial board of directors of the applicant or loan recipient before it has begun accepting enrollment and had an election by the members of the organization to the board of directors.

Individual market has the meaning given to the term in §155.20 of this subchapter.

Issuer has the meaning given to the term in §155.20 of this subchapter.

Member means an individual covered under health insurance policies issued by a loan recipient.

Nonprofit member organization or non-profit member corporation means a non-profit, not-for-profit, public benefit, or similar membership entity organized as appropriate under State law.

Operational board means the board of directors elected by the members of the loan recipient after it has begun accepting enrollment.

Predecessor, with respect to a new entity, means any entity that participates

in a merger, consolidation, purchase or acquisition of property or stock, corporate separation, or other similar business transaction that results in the formation of the new entity.

Pre-existing issuer means a health insurance issuer that was in existence on July 16, 2009.

Qualified nonprofit health insurance issuer means an entity that satisfies or can reasonably be expected to satisfy the standards in section 1322(c) of the Affordable Care Act and §156.515 of this subpart within the time frames specified in this subpart, until such time as CMS determines the entity does not satisfy or cannot reasonably be expected to satisfy these standards.

Related entity means an entity that shares common ownership, control, or governance structure (including management team or Board members) with a pre-existing issuer, and satisfies at least one of the following conditions:

(1) Retains responsibilities for the services to be provided by the issuer.

(2) Furnishes services to the issuer's enrollees under an oral or written agreement.

(3) Performs some of the issuer's management functions under contract or delegation.

Representative means an individual who stands or acts for an organization or group of organizations through a formal agreement or financial compensation such as a contractor, broker, official, or employee.

SHOP has the meaning given to the term in §155.20 of this subchapter.

Small group market has the meaning given to the term in §155.20 of this subchapter.

Solvency Loan means a loan provided by CMS to a loan recipient in order to meet State solvency and reserve requirements.

Sponsor means an organization or individual that is involved in the development, creation, or organization of the CO-OP or provides 40 percent or more in total funding to a CO-OP (excluding any loans received from the CO-OP Program).

Start-up Loan means a loan provided by CMS to a loan recipient for costs associated with establishing a CO-OP.

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State has the meaning given to the term in § 155.20 of this subchapter.

[76 FR 77411, Dec. 13, 2011, as amended at 77 FR 18474, Mar. 27, 2012]

§ 156.510 Eligibility.

(a) *General.* In addition to the eligibility standards set forth in the CO-OP program Funding Opportunity Announcement (FOA), to be eligible to apply for and receive a loan under the CO-OP program, an organization must intend to become a CO-OP and be a nonprofit member organization.

(b) *Exclusions from eligibility.* (1) Subject to paragraph (b)(2) of this section, an organization is not eligible to apply for a loan if:

(i) The organization or a sponsor of the organization is a pre-existing issuer, a holding company (an organization that exists primarily to hold stock in other companies) that controls a pre-existing issuer, a trade association comprised of pre-existing issuers and whose purpose is to represent the interests of the health insurance industry, a foundation established by a pre-existing issuer, a related entity, or a predecessor of either a pre-existing issuer or related entity;

(ii) The organization receives 25 percent or more of its total funding (excluding any loans received from the CO-OP Program) from pre-existing issuers, holding companies (organizations that exist primarily to hold stock in other companies) that control pre-existing issuers, trade associations comprised of pre-existing issuers and whose purpose is to represent the interests of the health insurance industry, foundations established by a pre-existing issuer, a related entity, or a predecessor of either a pre-existing issuer or related entity; or

(iii) A State or local government, any political subdivision thereof, or any instrumentality of such government or political subdivision is a sponsor of the organization. The organization receives 40 percent or more of its total funding (excluding any loans received from the CO-OP Program) from a State or local government, any political subdivision thereof, or any instrumentality of such a government or political subdivision.

(2) The exclusions in paragraphs (b)(1)(i) and (b)(1)(ii) of this section do

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not exclude from eligibility an applicant that:

(i) Has as a sponsor a nonprofit, not-for-profit, public benefit, or similarly organized entity that is also a sponsor for a pre-existing issuer but is not an issuer, a foundation established by a pre-existing issuer, a holding company that controls a pre-existing issuer, or a trade association comprised of pre-existing issuers and whose purpose is to represent the interests of the health insurance industry, provided that the pre-existing issuer sponsored by the nonprofit organization does not share any of its board or the same chief executive with the applicant; or

(ii) Has purchased assets from a pre-existing issuer provided that it is an arm's-length transaction where each party acts independently and has no other relationship with the other party.

(3) The exclusion of any instrumentality of a State or local government in paragraph (b)(1)(iii) of this section does not exclude from eligibility or sponsorship an organization that:

(i) Is not a government organization under State law;

(ii) Has no employee of a State or local government serving in his or her official capacity as a senior executive (for example, President, Chief Executive Officer, or Chief Financial Officer) for the organization; and

(iii) Has a board of directors on which fewer than half of its directors are employees of a State or local government serving in their official capacities.

[76 FR 77411, Dec. 13, 2011, as amended at 77 FR 18474, Mar. 27, 2012]

§ 156.515 CO-OP standards.

(a) *General.* A CO-OP must satisfy the standards in this section in addition to all other statutory, regulatory, or other requirements.

(b) *Governance requirements.* A CO-OP must meet the following governance requirements:

(1) *Member control.* A CO-OP must implement policies and procedures to foster and ensure member control of the organization. Accordingly, a CO-OP must meet the following requirements:

(i) The CO-OP must be governed by an operational board with all of its directors elected by a majority vote of a

quorum of the CO-OP's members that are age 18 or older;

(ii) All members age 18 or older must be eligible to vote for each director on the organization's operational board;

(iii) Each member age 18 or older of the organization must have one vote in the election of each director of the organization's operational board;

(iv) The first elected directors of the organization's operational board must be elected no later than one year after the effective date on which the organization provides coverage to its first member; the entire operational board must be elected no later than two years after the same date;

(v) Elections of the directors on the organization's operational board must be contested so that the total number of candidates for vacant positions on the operational board exceeds the number of vacant positions, except in cases where a seat is vacated mid-term due to death, resignation, or removal; and

(vi) The majority of the voting directors on the operational board must be members of the organization.

(2) *Standards for board of directors.* The operational board for a CO-OP must meet the following standards:

(i) Each director must meet ethical, conflict-of-interest, and disclosure standards including that each director act in the sole interest of the CO-OP and, as appropriate, the health and wellbeing of its local geographic community;

(ii) Each director has one vote unless he or she is a non-voting director;

(iii) Positions on the board of directors may be designated for individuals with specialized expertise, experience, or affiliation (for example, providers, employers, and unions);

(iv) Positions on the operational board that are designated for individuals with specialized expertise, experience, or affiliation cannot constitute a majority of the operational board even if the individuals in those positions are members of the CO-OP. This provision does not prevent any individual from seeking election to the operational board based on being a member of the CO-OP; and

(v) *Limitation on government and issuer participation.* No representative of any Federal, State or local government (or

of any political subdivision or instrumentality thereof) and no representative of any organization described in §156.510(b)(1)(i) may serve on the CO-OP's formation board or operational board.

(3) *Ethics and conflict of interest protections.* The CO-OP must have governing documents that incorporate ethics, conflict of interest, and disclosure standards. The standards must protect against insurance industry involvement and interference. In addition, the standards must ensure that each director acts in the sole interest of the CO-OP, its members, and its local geographic community as appropriate, avoids self dealing, and acts prudently and consistently with the terms of the CO-OP's governance documents and applicable State and Federal law. At a minimum, these standards must include:

(i) A mechanism to identify potential ethical or other conflicts of interest;

(ii) A duty on the CO-OP's executive officers and directors to disclose all potential conflicts of interest;

(iii) A process to determine the extent to which a conflict exists;

(iv) A process to address any conflict of interest; and

(v) A process to be followed in the event a director or executive officer of the CO-OP violates these standards.

(4) *Consumer focus.* The CO-OP must operate with a strong consumer focus, including timeliness, responsiveness, and accountability to members.

(c) *Standards for health plan issuance.* A CO-OP must meet several standards for the issuance of health plans in the individual and small group market.

(1) At least two-thirds of the policies or contracts for health insurance coverage issued by a CO-OP in each State in which it is licensed must be CO-OP qualified health plans offered in the individual and small group markets.

(2) Loan recipients must offer a CO-OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in every individual market Exchange that serves the geographic regions in which the organization is licensed and intends to provide health care coverage. If offering at least one plan in

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the small group market, loan recipients must offer a CO-OP qualified health plan at both the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in each SHOP that serves the geographic regions in which the organization offers coverage in the small group market.

(3) Within the earlier of thirty-six months following the initial drawdown of the Start-up Loan or one year following the initial drawdown of the Solvency Loan, loan recipients must be licensed in a State and offer at least one CO-OP qualified health plan at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the individual market Exchanges and if the loan recipient offers coverage in the small group market, at the silver and gold benefit levels, defined in section 1302(d) of the Affordable Care Act, in the SHOPS. Loan recipients may only begin offering plans and accepting enrollment in the Exchanges for new CO-OP qualified health plans during the open enrollment period for each applicable Exchange.

(d) *Requirement to become a CO-OP.* Loan recipients must meet the standards of §156.515 no later than five years following initial drawdown of the Start-up Loan or three years following the initial drawdown of a Solvency Loan.

§ 156.520 Loan terms.

(a) *Overview of Loans.* Applicants may apply for the following loans under this section: Start-up Loans and Solvency Loans.

(1) *Use of loans.* All loans awarded under this subpart must be used in a manner that is consistent with the FOA, the loan agreement, and all other statutory, regulatory, or other requirements.

(2) *Solvency loans.* Solvency Loans awarded under this section will be structured in a manner that ensures that the loan amount is recognized by State insurance regulators as contributing to the State-determined reserve requirements or other solvency requirements (rather than debt) consistent with the insurance regulations for the States in which the loan recipi-

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ent will offer a CO-OP qualified health plan.

(b) *Repayment period.* The loan recipient must make loan payments consistent with the approved repayment schedule in the loan agreement until the loan is paid in full consistent with State reserve requirements, solvency regulations, and requisite surplus note arrangements. Subject to their ability to meet State reserve requirements, solvency regulations, or requisite surplus note arrangements, the loan recipient must repay its loans and, if applicable, penalties within the repayment periods in paragraphs (b)(1), (b)(2), or (b)(3) of this section.

(1) The contractual repayment period for Start-up Loans and any applicable penalty pursuant to paragraph (c)(3) of this section is 5 years following each drawdown of loan funds consistent with the terms of the loan agreement.

(2) The contractual repayment period for Solvency Loans and any applicable penalty pursuant to paragraph (c)(3) of this section is 15 years following each drawdown of loan funds consistent with the terms of the loan agreement.

(3) Changes to the loan terms, including the repayment periods, may be executed if CMS determines that the loan recipient is unable to repay the loans as a result of State reserve requirements, solvency regulations, or requisite surplus note arrangements or without compromising coverage stability, member control, quality of care, or market stability. In the case of a loan modification or workout, the repayment period for loans awarded under this subpart is the repayment period established in the loan modification or workout. The revised terms must meet all other regulatory, statutory, and other requirements.

(c) *Interest rates.* Loan recipients will be charged interest for the loans awarded under this subpart. Interest will be accrued starting from the date of drawdown on the loan amounts that have been drawn down and not yet repaid by the loan recipient. The interest rate will be determined based on the date of award.

(1) *Start-up Loans.* Consistent with the terms of the loan agreement, the interest rate for Start-up Loans is

equal to the greater of the average interest rate on marketable Treasury securities of similar maturity minus one percentage point or zero percent. If the loan recipient's loan agreement is terminated by CMS, the loan recipient will be charged the interest and penalty described in paragraph (c)(3) of this section.

(2) *Solvency Loans.* Consistent with the terms of the loan agreement, the interest rate for Solvency Loans is equal to the greater of the average interest rate on marketable Treasury securities of similar maturity minus two percentage points or zero percent. If a loan recipient's loan agreement is terminated by CMS, the loan recipient will be charged the interest and penalty described in paragraph (c)(3) of this section.

(3) *Penalty payment.* If CMS terminates a loan recipient's loan agreement because the loan recipient is not in compliance with program rules or the terms of its loan agreement, or CMS has reason to believe that the organization engages in, or has engaged in, criminal or fraudulent activities or activities that cause material harm to the organization's members or the government, the loan recipient must repay 110 percent of the aggregate amount of loans received under this subpart. In addition, the loan recipient must pay interest on the aggregate amount of loans received for the period the loans were outstanding equal to the average interest rate on marketable Treasury securities of similar maturity.

(d) *Failure to pay.* Loan recipients that fail to make loan payments consistent with the repayment schedule or loan modification or workout approved by CMS will be subject to any and all remedies available to CMS under law to collect the debt.

(e) *Deeming of CO-OP qualified health plans.* Health plans offered by a loan recipient may be deemed certified as a CO-OP qualified health plan to participate in the Exchanges for two years and may be recertified every two years for up to ten years following the life of any loan awarded to the loan recipient under this subpart, consistent with section 1301(a)(2) of the Affordable Care Act.

(1) To be deemed as certified to participate in the Exchanges, the plan must comply with the standards for CO-OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act, all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO-OP, and the standards of the CO-OP program as set forth in this subpart.

(2) A loan recipient seeking to have a plan deemed as certified to participate in the Exchanges must provide evidence to CMS or an entity designated by CMS that the plan complies with the standards for CO-OP qualified health plans set forth pursuant to section 1311(c) of the Affordable Care Act, all State-specific standards established by an Exchange for qualified health plans operating in that Exchange, except for those State-specific standards that operate to exclude loan recipients due to being new issuers or based on other characteristics that are inherent in the design of a CO-OP, and the standards of the CO-OP program as set forth in this subpart.

(3) If a plan offered by a loan recipient is deemed to be certified to participate in the Exchanges or loses its deemed status and is no longer certified to participate in the Exchanges, CMS or an entity designated by CMS will provide notice to the Exchanges in which the loan recipient offers CO-OP qualified health plans.

(f) *Conversions.* The loan recipient shall not convert or sell to a for-profit or non-consumer operated entity at any time after receiving a loan under this subpart. The loan recipient shall not undertake any transaction that would result in the CO-OP implementing a governance structure that does not meet the standards in this subpart.

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