(A) The qualified individual has not been determined eligible for advance payments of the premium tax credit or cost-sharing reductions; or

(B) The qualified individual pays the entire premium for the first partial month of coverage as well as all cost sharing, thereby waiving the benefit of advance payments of the premium tax credit and cost-sharing reduction payments until the first of the next month.

(ii) For a QHP selection received by the Exchange from a qualified individual on a date set by the Exchange after the fifteenth of the month, the Exchange may provide a coverage effective date of the first of the following month.

(c) *Length of special enrollment periods.* Unless specifically stated otherwise herein, a qualified individual or enrollee has 60 days from the date of a triggering event to select a QHP.

(d) *Special enrollment periods.* The Exchange must allow qualified individuals and enrollees to enroll in or change from one QHP to another as a result of the following triggering events:

(1) A qualified individual or dependent loses minimum essential coverage;

(2) A qualified individual gains a dependent or becomes a dependent through marriage, birth, adoption or placement for adoption;

(3) An individual, who was not previously a citizen, national, or lawfully present individual gains such status;

(4) A qualified individual's enrollment or non-enrollment in a QHP is unintentional, inadvertent, or erroneous and is the result of the error, misrepresentation, or inaction of an officer, employee, or agent of the Exchange or HHS, or its instrumentalities as evaluated and determined by the Exchange. In such cases, the Exchange may take such action as may be necessary to correct or eliminate the effects of such error, misrepresentation, or inaction;

(5) An enrollee adequately demonstrates to the Exchange that the QHP in which he or she is enrolled substantially violated a material provision of its contract in relation to the enrollee;

(6) An individual is determined newly eligible or newly ineligible for advance payments of the premium tax credit or has a change in eligibility for cost-sharing reductions, regardless of whether such individual is already enrolled in a QHP. The Exchange must permit individuals whose existing coverage through an eligible employer-sponsored plan will no longer be affordable or provide minimum value for his or her employer's upcoming plan year to access this special enrollment period prior to the end of his or her coverage through such eligible employer-sponsored plan;

(7) A qualified individual or enrollee gains access to new QHPs as a result of a permanent move;

(8) An Indian, as defined by section 4 of the Indian Health Care Improvement Act, may enroll in a QHP or change from one QHP to another one time per month; and

(9) A qualified individual or enrollee demonstrates to the Exchange, in accordance with guidelines issued by HHS, that the individual meets other exceptional circumstances as the Exchange may provide.

(e) *Loss of minimum essential coverage.* Loss of minimum essential coverage includes those circumstances described in 26 CFR 54.9801–6(a)(3)(i) through (iii). Loss of coverage does not include termination or loss due to—

(1) Failure to pay premiums on a timely basis, including COBRA premiums prior to expiration of COBRA coverage, or

(2) Situations allowing for a rescission as specified in 45 CFR 147.128.

§ 155.430 Termination of coverage.

(a) *General requirements.* The Exchange must determine the form and manner in which coverage in a QHP may be terminated.

(b) *Termination events.* (1) The Exchange must permit an enrollee to terminate his or her coverage in a QHP, including as a result of the enrollee obtaining other minimum essential coverage, with appropriate notice to the Exchange or the QHP.

(2) The Exchange may initiate termination of an enrollee's coverage in a QHP, and must permit a QHP issuer to

terminate such coverage, in the following circumstances:

(i) The enrollee is no longer eligible for coverage in a QHP through the Exchange;

(ii) Non-payment of premiums for coverage of the enrollee, and

(A) The 3-month grace period required for individuals receiving advance payments of the premium tax credit has been exhausted as described in §156.270(g); or,

(B) Any other grace period not described in paragraph (b)(2)(ii)(A) of this section has been exhausted;

(iii) The enrollee's coverage is rescinded in accordance with §147.128 of this subtitle;

(iv) The QHP terminates or is decertified as described in §155.1080; or

(v) The enrollee changes from one QHP to another during an annual open enrollment period or special enrollment period in accordance with §155.410 or §155.420.

(c) *Termination of coverage tracking and approval.* The Exchange must—

(1) Establish mandatory procedures for QHP issuers to maintain records of termination of coverage;

(2) Send termination information to the QHP issuer and HHS, promptly and without undue delay in accordance with §155.400(b).

(3) Require QHP issuers to make reasonable accommodations for all individuals with disabilities (as defined by the Americans with Disabilities Act) before terminating coverage for such individuals; and

(4) Retain records in order to facilitate audit functions.

(d) *Effective dates for termination of coverage.* (1) For purposes of this section, reasonable notice is defined as fourteen days from the requested effective date of termination.

(2) In the case of a termination in accordance with paragraph (b)(1) of this section, the last day of coverage is—

(i) The termination date specified by the enrollee, if the enrollee provides reasonable notice;

(ii) Fourteen days after the termination is requested by the enrollee, if the enrollee does not provide reasonable notice; or

(iii) On a date determined by the enrollee's QHP issuer, if the enrollee's QHP issuer is able to effectuate termination in fewer than fourteen days and the enrollee requests an earlier termination effective date.

(iv) If the enrollee is newly eligible for Medicaid, CHIP, or the BHP, if a BHP is operating in the service area of the Exchange, the last day of coverage is the day before such coverage begins.

(3) In the case of a termination in accordance with paragraph (b)(2)(i) of this section, the last day of coverage is the last day of the month following the month in which the notice described in §155.330(e)(1)(ii) is sent by the Exchange unless the individual requests an earlier termination effective date per paragraph (b)(1) of this section.

(4) In the case of a termination in accordance with paragraph (b)(2)(ii)(A) of this section, the last day of coverage will be the last day of the first month of the 3-month grace period.

(5) In the case of a termination in accordance with paragraph (b)(2)(ii)(B) of this section, the last day of coverage should be consistent with existing State laws regarding grace periods.

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP.

[77 FR 18444, Mar. 27, 2012, as amended at 77 FR 31515, May 29, 2012]

Subparts B Through G [Reserved]

Subpart H—Exchange Functions: Small Business Health Options Program (SHOP)

SOURCE: 77 FR 18464, Mar. 27, 2012, unless otherwise noted.

§155.700 Standards for the establishment of a SHOP.

(a) *General requirement.* An Exchange must provide for the establishment of a SHOP that meets the requirements of this subpart and is designed to assist qualified employers and facilitate the enrollment of qualified employees into qualified health plans.

(b) *Definition.* For the purposes of this subpart: