

§ 156.280

45 CFR Subtitle A (10–1–12 Edition)

(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;