

issuer group offers through a Federally-facilitated SHOP serving that State at least one small group market QHP at the silver level of coverage and one at the gold level of coverage; or

(3) Neither the issuer nor any other issuer in the same issuer group has a share of the small group market, as determined by HHS, greater than 20 percent, based on the earned premiums submitted by all issuers in the State's small group market, under §158.110 of this subchapter, on the reporting date immediately preceding the due date of the application for QHP certification.

[77 FR 18469, Mar. 27, 2012, as amended at 78 FR 15535, Mar. 11, 2013]

**§ 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.

(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.

**§ 156.215 Advance payments of the premium tax credit and cost-sharing reduction standards.**

(a) *Standards relative to advance payments of the premium tax credit and cost-sharing reductions.* In order for a health plan to be certified as a QHP initially and to maintain certification to be offered in the individual market on the Exchange, the issuer must meet the requirements related to the administration of cost-sharing reductions and advance payments of the premium tax credit set forth in subpart E of this part.

(b) [Reserved]

[78 FR 15535, Mar. 11, 2013]

**§ 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.

**§ 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