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.

(7) A QHP issuer must enroll a qualified employee only if the SHOP —

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

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

(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)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage established in §155.735 of this subchapter, if applicable to the coverage being terminated; otherwise

(B) General requirements regarding termination of coverage established in §156.270(a) of this subchapter.

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

(iii)(A) Effective in plan years beginning on or after January 1, 2015, requirements regarding termination of coverage effective dates as set forth in §155.735 of this subchapter, if applicable to the coverage being terminated; otherwise

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

(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.

[77 FR 18469, Mar. 27, 2012, as amended at 78 FR 15535, Mar. 11, 2013; 78 FR 33240, June 4, 2013; 78 FR 54143, Aug. 30, 2013]

§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;

(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 manufacturer 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.

Subpart D—Federally-Facilitated Exchange Qualified Health Plan Issuer Standards

SOURCE: 78 FR 54143, Aug. 30, 2013, unless otherwise noted.

§ 156.340 Standards for downstream and delegated entities.

(a) *General requirement.* Effective October 1, 2013, notwithstanding any relationship(s) that a QHP issuer may have with delegated and downstream entities, a QHP issuer maintains responsibility for its compliance and the compliance of any of its delegated or downstream entities, as applicable, with all applicable standards, including—

(1) Standards of subpart C of part 156 with respect to each of its QHPs on an ongoing basis;

(2) Exchange processes, procedures, and standards in accordance with subparts H and K of part 155 and, in the small group market, §155.705 of this subchapter;

(3) Standards of §155.220 of this subchapter with respect to assisting with enrollment in QHPs; and

(4) Standards of §§156.705 and 156.715 for maintenance of records and compliance reviews for QHP issuers operating in a Federally-facilitated Exchange or FF–SHOP.

(b) *Delegation agreement specifications.* If any of the QHP issuer's activities or obligations, in accordance with paragraph (a) of this section, are delegated to other parties, the QHP issuer's