through (e) of this section, if the termination of coverage effective date is prior to the determination of termination other than in the circumstances described in paragraph (f)(1) of this section, and if the reason for the termination (or late determination thereof) is not the fault of the QHP issuer, as reasonably determined by the Exchange, the QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during such period.

(4) Subject to the requirements of the cost-sharing reduction reconciliation process described in paragraphs (c) through (e) of this section, a QHP issuer will be eligible for advance payments and reimbursement for cost-sharing reductions provided during any period of coverage pending resolution of inconsistencies in information required to determine eligibility for enrollment under §155.315(f) of this subchapter.

(g) *Prohibition on reduction in payments to Indian health providers.* If an Indian is enrolled in a QHP in the individual market through an Exchange and is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization, or through referral under contract health services, the QHP issuer may not reduce the payment to any such entity for such item or service by the amount of any cost sharing that would be due from the Indian but for the prohibitions on cost sharing set forth in §156.410(b)(2) and (3).

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§156.440 Plans eligible for advance payments of the premium tax credit and cost-sharing reductions.

Except as noted in paragraph (a) through (c) of this section, the provisions of this subpart apply to qualified health plans offered in the individual market on the Exchange.

(a) *Catastrophic plans.* The provisions of this subpart do not apply to catastrophic plans described in §156.155.

(b) *Stand-alone dental plans.* The provisions of this subpart, to the extent relating to cost-sharing reductions, do not apply to stand-alone dental plans. The provisions of this subpart, to the extent relating to advance payments of the premium tax credit, apply to stand-alone dental plans.

(c) *Child-only plans.* The provisions of this subpart apply to child-only QHPs, described in §156.200(c)(2).

§156.460 Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.

(a) *Reduction of enrollee's share of premium to account for advance payments of the premium tax credit.* A QHP issuer that receives notice from the Exchange that an individual enrolled in the issuer's QHP is eligible for an advance payment of the premium tax credit must—

(1) Reduce the portion of the premium charged to or for the individual for the applicable month(s) by the amount of the advance payment of the premium tax credit;

(2) Notify the Exchange of the reduction in the portion of the premium charged to the individual in accordance with §156.265(g); and

(3) Include with each billing statement, as applicable, to or for the individual the amount of the advance payment of the premium tax credit for the applicable month(s), and the remaining premium owed.

(b) *Delays in payment.* A QHP issuer may not refuse to commence coverage under a policy or terminate coverage on account of any delay in payment of an advance payment of the premium tax credit on behalf of an enrollee if the QHP issuer has been notified by the Exchange under §155.340(a) of this subchapter that the QHP issuer will receive such advance payment.

§156.470 Allocation of rates and claims costs for advance payments of cost-sharing reductions and the premium tax credit.

(a) *Allocation to additional health benefits for QHPs.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each health plan at any level of coverage offered, or intended to be offered, in the individual market on an Exchange, an allocation of the rate and the expected allowed claims costs for the plan, in each case, to:

(1) EHB, other than services described in § 156.280(d)(1), and

(2) Any other services or benefits offered by the health plan not described paragraph (a)(1) of this section.

(b) *Allocation to additional health benefits for stand-alone dental plans.* An issuer must provide to the Exchange annually for approval, in the manner and timeframe established by HHS, for each stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange, a dollar allocation of the expected premium for the plan, to:

(1) The pediatric dental essential health benefit, and

(2) Any benefits offered by the stand-alone dental plan that are not the pediatric dental essential health benefit.

(c) *Allocation standards for QHPs.* The issuer must ensure that the allocation described in paragraph (a) of this section—

(1) Is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies;

(2) Reasonably reflects the allocation of the expected allowed claims costs attributable to EHB (excluding those services described in § 156.280(d)(1));

(3) Is consistent with the allocation applicable to State-required benefits to be submitted by the issuer under § 155.170(c) of this subchapter, and the allocation requirements described in § 156.280(e)(4) for certain services; and

(4) Is calculated under the fair health insurance premium standards described at 45 CFR 147.102, the single risk pool standards described at 45 CFR 156.80, and the same premium rate standards described at 45 CFR 156.255.

(d) *Allocation standards for stand-alone dental plans.* The issuer must ensure that the dollar allocation described in paragraph (b) of this section is performed by a member of the American Academy of Actuaries in accordance with generally accepted actuarial principles and methodologies.

(e) *Disclosure of attribution and allocation methods.* An issuer of a health plan at any level of coverage or a stand-alone dental plan offered, or intended to be offered, in the individual market on the Exchange must submit to the Exchange annually for approval, an actuarial memorandum, in the manner and timeframe specified by HHS, with a detailed description of the methods and specific bases used to perform the allocations set forth in paragraphs (a) and (b), and demonstrating that the allocations meet the standards set forth in paragraphs (c) and (d) of this section, respectively.

(f) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must submit the allocations and actuarial memorandum described in this section to the U.S. Office of Personnel Management, in the time and manner established by the U.S. Office of Personnel Management.

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.