new evidence that was not presented with the reconsideration request and HHS statement under paragraph (b) of this section. The CMS hearing officer will review only the documentary evidence provided by the issuer and HHS, and the record that was before HHS when HHS made its reconsideration determination. The issuer may be represented by counsel in the informal hearing, and must prove its case by clear and convincing evidence with respect to issues of fact.

(4) *Decision of the CMS hearing officer.* The CMS hearing officer will send the informal hearing decision and the reasons for the decision to the issuer. The decision of the CMS hearing officer is final and binding, but is subject to the results of any Administrator's review initiated in accordance with paragraph (c) of this section.

(c) *Review by the Administrator.* (1) If the CMS hearing officer upholds the reconsideration decision, the issuer may request review by the Administrator of CMS within 15 calendar days of the date of the CMS hearing officer's decision. The request for review must specify the findings or issues that the issuer challenges. HHS may submit for review by the Administrator a statement supporting the decision of the CMS hearing officer.

(2) The Administrator will review the CMS hearing officer's decision, the statements of the issuer and HHS, and any other information included in the record of the CMS hearing officer's decision, and will determine whether to uphold, reverse, or modify the CMS hearing officer's decision. The issuer must provide its case by clear and convincing evidence with respect to issues of fact. The Administrator will send the decision and the reasons for the decisions to the issuer.

(3) The Administrator's determination is final and binding.

[79 FR 13841, Mar. 11, 2014]

§ 156.1230 Direct enrollment with the QHP issuer in a manner considered to be through the Exchange.

(a) A QHP issuer that is directly contacted by a potential applicant may, at the Exchange's option, enroll such applicant in a QHP in a manner that is considered through the Exchange. In order for the enrollment to be made directly with the issuer in a manner that is considered to be through the Exchange, the QHP issuer needs to comply with at least the following requirements:

(1) *QHP issuer general requirements.* (i) The QHP issuer follows the enrollment process for qualified individuals consistent with § 156.265.

(ii) The QHP issuer's Web site provides applicants the ability to view QHPs offered by the issuer with the data elements listed in § 155.205(b)(1)(i) through (viii) of this subchapter.

(iii) The QHP issuer's Web site clearly distinguishes between QHPs for which the consumer is eligible and other non-QHPs that the issuer may offer, and indicate that advance payments of the premium tax credit and cost sharing reductions apply only to QHPs offered through the Exchange.

(iv) The QHP issuer informs all applicants of the availability of other QHP products offered through the Exchange through an HHS-approved universal disclaimer and displays the Web link to and describes how to access the Exchange Web site.

(v) The QHP issuer's Web site allows applicants to select and attest to an advance payment of the premium tax credit amount, if applicable, in accordance with § 155.310(d)(2) of this subchapter.

(2) *QHP issuer application assister eligibility application assistance requirements.* If permitted by the Exchange pursuant to § 155.415 of this subchapter, and to the extent permitted by State law, a QHP issuer may permit its issuer application assisters, as defined at § 155.20, to assist individuals in the individual market with applying for a determination or redetermination of eligibility for coverage through the Exchange and for insurance affordability programs, provided that such issuer ensures that each of its application assisters at least-

(i) Receives training on QHP options and insurance affordability programs, eligibility, and benefits rules and regulations;

(ii) Complies with the Exchange's privacy and security standards adopted consistent with § 155.260 of this subchapter; and

(iii) Complies with applicable State law related to the sale, solicitation, and negotiation of health insurance products, including applicable State law related to agent, broker, and producer licensure; confidentiality; and conflicts of interest.

(b) *Direct enrollment in a Federally-facilitated Exchange.* The individual market Federally-facilitated Exchanges will permit issuers of QHPs in each Federally-facilitated Exchange to directly enroll applicants in a manner that is considered to be through the Exchange, pursuant to paragraph (a) of this section, to the extent permitted by applicable State law.

§ 156.1240 Enrollment process for qualified individuals.

(a) *Premium payment.* A QHP issuer must—

(1) Follow the premium payment process established by the Exchange in accordance with § 155.240.

(2) At a minimum, for all payments in the individual market, accept paper checks, cashier's checks, money orders, EFT, and all general-purpose pre-paid debit cards as methods of payment and present all payment method options equally for a consumer to select their preferred payment method.

(b) [Reserved]

§ 156.1250 Acceptance of certain third party payments.

Issuers offering individual market QHPs, including stand-alone dental plans, must accept premium and cost-sharing payments from the following third-party entities on behalf of plan enrollees:

(a) Ryan White HIV/AIDS Program under title XXVI of the Public Health Service Act;

(b) Indian tribes, tribal organizations or urban Indian organizations; and

(c) State and Federal Government programs.

[79 FR 15245, Mar. 19, 2014]

§ 156.1255 Renewal and re-enrollment notices.

A health insurance issuer that is renewing an enrollment group's coverage in an individual market QHP offered through the Exchange (including a renewal with modifications) in accordance with § 147.106 of this subchapter, or that is nonrenewing coverage offered through the Exchange and automatically enrolling an enrollee in a QHP under a different product offered by the same QHP issuer through the Exchange in accordance with § 155.335 of this subchapter, must include the following information in the applicable notice described in § 147.106(b)(5), (c)(1), or (f)(1) of this subchapter:

(a) Premium and advance payment of the premium tax credit information sufficient to notify the enrollment group of its expected monthly premium payment under the renewed coverage, in a form and manner specified by the Exchange, provided that if the Exchange does not provide this information to enrollees and does not require issuers to provide this information to enrollees, consistent with this section, such information must be provided in a form and manner specified by HHS;

(b) An explanation of the requirement to report changes to the Exchange, as specified in § 155.335(e) of this subchapter, the timeframe and channels through which changes can be reported, and the implications of not reporting changes;

(c) For an enrollment group that includes an enrollee on whose behalf advance payments of the premium tax credit are being provided, an explanation of the reconciliation process for advance payments of the premium tax credit established in accordance with 26 CFR 1.36B–4; and

(d) For an enrollment group that includes an enrollee being provided cost-sharing reductions, but for whom no QHP under the product remains available for renewal at the silver level, an explanation that in accordance with § 155.305(g)(1)(ii) of this subchapter, cost-sharing reductions are only available to an individual who is not an Indian if he or she is enrolled in a silver-level QHP.

EFFECTIVE DATE NOTE: At 79 FR 53006, Sept. 5, 2014, § 156.1255 was added, effective Oct. 6, 2014.