§ 156.270 Termination of coverage for qualified individuals.

(a) *General requirement.* A QHP issuer may only terminate coverage as permitted by the Exchange in accordance with §155.430(b) of this subchapter.

(b) *Termination of coverage notice requirement.* If a QHP issuer terminates an enrollee's coverage in accordance with §155.430(b)(2)(i), (ii), or (iii), the QHP issuer must, promptly and without undue delay:

(1) Provide the enrollee with a notice of termination of coverage that includes the termination effective date and reason for termination.

(2) [Reserved]

(c) *Termination of coverage due to non-payment of premium.* A QHP issuer must establish a standard policy for the termination of coverage of enrollees due to non-payment of premium as permitted by the Exchange in §155.430(b)(2)(ii) of this subchapter. This policy for the termination of coverage:

(1) Must include the grace period for enrollees receiving advance payments of the premium tax credits as described in paragraph (d) of this section; and

(2) Must be applied uniformly to enrollees in similar circumstances.

(d) *Grace period for recipients of advance payments of the premium tax credit.* A QHP issuer must provide a grace period of three consecutive months if an enrollee receiving advance payments of the premium tax credit has previously paid at least one full month's premium during the benefit year. During the grace period, the QHP issuer must:

(1) Pay all appropriate claims for services rendered to the enrollee during the first month of the grace period and may pend claims for services rendered to the enrollee in the second and third months of the grace period;

(2) Notify HHS of such non-payment; and,

(3) Notify providers of the possibility for denied claims when an enrollee is in the second and third months of the grace period.

(e) *Advance payments of the premium tax credit.* For the 3-month grace period described in paragraph (d) of this section, a QHP issuer must:

(1) Continue to collect advance payments of the premium tax credit on behalf of the enrollee from the Department of the Treasury.

(2) Return advance payments of the premium tax credit paid on the behalf of such enrollee for the second and third months of the grace period if the enrollee exhausts the grace period as described in paragraph (g) of this section.

(f) *Notice of non-payment of premiums.* If an enrollee is delinquent on premium payment, the QHP issuer must provide the enrollee with notice of such payment delinquency.

(g) *Exhaustion of grace period.* If an enrollee receiving advance payments of the premium tax credit exhausts the 3-month grace period in paragraph (d) of this section without paying all outstanding premiums, the QHP issuer must terminate the enrollee's coverage on the effective date described in §155.430(d)(4) of this subchapter, provided that the QHP issuer meets the notice requirement specified in paragraph (b) of this section.

(h) *Records of termination of coverage.* QHP issuers must maintain records in accordance with Exchange standards established in accordance with §155.430(c) of this subchapter.

(i) *Effective date of termination of coverage.* QHP issuers must abide by the termination of coverage effective dates described in §155.430(d) of this subchapter.

(j) *Operational instructions.* QHP issuers must follow the transaction rules established by the Exchange in accordance with §155.430(e) of this subchapter.

[77 FR 18469, Mar. 27, 2012, as amended at 78 FR 42322, July 15, 2013; 78 FR 54143, Aug. 30, 2013; 79 FR 30351, May 27, 2014]

§ 156.275 Accreditation of QHP issuers.

(a) *General requirement.* A QHP issuer must:

(1) Be accredited on the basis of local performance of its QHPs in the following categories by an accrediting entity recognized by HHS:

(i) Clinical quality measures, such as the Healthcare Effectiveness Data and Information Set;

(ii) Patient experience ratings on a standardized CAHPS survey;

(iii) Consumer access;

(iv) Utilization management;

(v) Quality assurance;

(vi) Provider credentialing;

(vii) Complaints and appeals;

(viii) Network adequacy and access; and

(ix) Patient information programs, and

(2) Authorize the accrediting entity that accredits the QHP issuer to release to the Exchange and HHS a copy of its most recent accreditation survey, together with any survey-related information that HHS may require, such as corrective action plans and summaries of findings.

(b) *Timeframe for accreditation.* A QHP issuer must be accredited within the timeframe established by the Exchange in accordance with §155.1045 of this subchapter. The QHP issuer must maintain accreditation so long as the QHP issuer offers QHPs.

(c) *Accreditation*—(1) *Recognition of accrediting entity by HHS*—(i) *Application.* An accrediting entity may apply to HHS for recognition. An application must include the documentation described in paragraph (c)(4) of this section and demonstrate, in a concise and organized fashion how the accrediting entity meets the requirements of paragraphs (c)(2) and (3) of this section.

(ii) *Proposed notice.* Within 60 days of receiving a complete application as described in paragraph (c)(1)(i) of this section, HHS will publish a notice in the FEDERAL REGISTER identifying the accrediting entity making the request, summarizing HHS's analysis of whether the accrediting entity meets the criteria described in paragraphs (c)(2) and (3) of this section, and providing no less than a 30-day public comment period about whether HHS should recognize the accrediting entity.

(iii) *Final notice.* After the close of the comment period described in paragraph (c)(1)(ii) of this section, HHS will notify the public in the FEDERAL REGISTER of the names of the accrediting entities recognized and those not recognized as accrediting entities by the Secretary of HHS to provide accreditation of QHPs.

(iv) *Other recognition.* Upon completion of conditions listed in paragraphs (c)(2), (3), and (4) of this section, HHS recognized, and provided notice to the public in the FEDERAL REGISTER, the National Committee for Quality Assurance (NCQA) and URAC as accrediting entities by the Secretary of HHS to provide accreditation of QHPs meeting the requirement of this section.

(2)(i) *Scope of accreditation.* Subject to paragraphs (c)(2)(ii), (iii), and (iv) of this section, recognized accrediting entities must provide accreditation within the categories identified in paragraphs (a)(1) of this section.

(ii) *Clinical quality measures.* Recognized accrediting entities must include a clinical quality measure set in their accreditation standards for health plans that:

(A) Spans a breadth of conditions and domains, including, but not limited to, preventive care, mental health and substance abuse disorders, chronic care, and acute care.

(B) Includes measures that are applicable to adults and measures that are applicable to children.

(C) Aligns with the priorities of the National Strategy for Quality Improvement in Health Care issued by the Secretary of HHS and submitted to Congress on March 12, 2011;

(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 of 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 applying to be recognized under the process described in (c)(1) of this section 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 it meets the conditions described in paragraphs (c)(2) and (3) of this section to HHS.

(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; 78 FR 12869, Feb. 25, 2013]

§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