provisions of subsection (b)(3)(C) of section 1927 of the Act.

§ 156.298 Meaningful difference standard for Qualified Health Plans in the Federally-facilitated Exchanges.

(a) *General.* Subject to paragraph (b)(2) of this section, starting in the 2015 coverage year, in order to be certified as a QHP offered through a Federally-facilitated Exchange, a plan must be meaningfully different from all other QHPs offered by the same issuer of that plan within a service area and level of coverage in the Exchange, as defined in paragraph (b) of this section.

(b) *Meaningful difference standard.* A plan is considered meaningfully different from another plan in the same service area and metal tier (including catastrophic plans) if a reasonable consumer would be able to identify one or more material differences among the following characteristics between the plan and other plan offerings:

(1) Cost sharing;

(2) Provider networks;

(3) Covered benefits;

(4) Plan type;

(5) Health Savings Account eligibility; or

(6) Self-only, non-self-only, or child-only plan offerings.

(c) *Exception for limited plan availability.* If HHS determines that the plan offerings at a particular metal level (including catastrophic plans) within a county are limited, plans submitted for certification in that particular metal level (including catastrophic plans) within that county will not be subject to the meaningful difference requirement set forth in paragraph (b) of this section.

(d) *Two-year transition period for issuers with new acquisitions.* During the first 2 years after a merger or acquisition in which an acquiring issuer obtains or merges with another issuer, the FFEs may certify plans as QHPs that were previously offered by the acquired or merged issuer without those plans meeting the meaningful difference standard set forth in paragraph (b) of this section.

[79 FR 13840, Mar. 11, 2014]

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

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

§ 156.330 Changes of ownership of issuers of Qualified Health Plans in Federally-facilitated Exchanges.

When a QHP issuer that offers one or more QHPs in a Federally-facilitated Exchange undergoes a change of ownership as recognized by the State in which the issuer offers the QHP, the QHP issuer must notify HHS of the change in a manner to be specified by HHS, and provide the legal name and Taxpayer Identification Number (TIN) of the new owner and the effective date of the change at least 30 days prior to the effective date of the change of ownership. The new owner must agree to adhere to all applicable statutes and regulations.

[78 FR 65096, Oct. 30, 2013]

§ 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 agreement with any delegated or downstream entity must—

(1) Specify the delegated activities and reporting responsibilities;

(2) Provide for revocation of the delegated activities and reporting standards or specify other remedies in instances where HHS or the QHP issuer determines that such parties have not performed satisfactorily;

(3) Specify that the delegated or downstream entity must comply with all applicable laws and regulations relating to the standards specified under paragraph (a) of this section;

(4) Specify that the delegated or downstream entity must permit access by the Secretary and the OIG or their designees in connection with their right to evaluate through audit, inspection, or other means, to the delegated or downstream entity's books, contracts, computers, or other electronic systems, including medical records and documentation, relating to the QHP issuer's obligations in accordance with Federal standards under paragraph (a) of this section until 10 years from the final date of the agreement period; and

(5) Contain specifications described in paragraph (b) of this section by no later than January 1, 2015, for existing agreements; and no later than the effective date of the agreement for agreements that are newly entered into as of October 1, 2013.

Subpart E—Health Insurance Issuer Responsibilities With Respect to Advance Payments of the Premium Tax Credit and Cost-Sharing Reductions

SOURCE: 78 FR 15535, Mar. 11, 2013, unless otherwise noted.

§ 156.400 Definitions.

The following definitions apply to this subpart:

Advance payments of the premium tax credit has the meaning given to the term in § 155.20 of this subchapter.

Affordable Care Act has the meaning given to the term in § 155.20 of this subchapter.

Annual limitation on cost sharing means the annual dollar limit on cost sharing required to be paid by an enrollee that is established by a particular qualified health plan.

De minimis variation means the allowable variation in the AV of a health plan that does not result in a material difference in the true dollar value of the health plan as established in § 156.140(c).

De minimis variation for a silver plan variation means a single percentage point.

Federal poverty level or *FPL* has the meaning given to the term in § 155.300(a) of this subchapter.

Indian has the meaning given to the term in § 155.300(a) of this subchapter.

Limited cost sharing plan variation means, with respect to a QHP at any level of coverage, the variation of such QHP described in § 156.420(b)(2).

Maximum annual limitation on cost sharing means the highest annual dollar amount that qualified health plans (other than QHPs with cost-sharing reductions) may require in cost sharing for a particular year, as established for that year under § 156.130.

Most generous or *more generous* means, as between a QHP (including a standard silver plan) or plan variation and one or more other plan variations of the same QHP, the standard plan or plan variation designed for the category of individuals last listed in § 155.305(g)(3) of this subchapter. *Least generous* or *less generous* has the opposite meaning.

Plan variation means a zero cost sharing plan variation, a limited cost sharing plan variation, or a silver plan variation.

Reduced maximum annual limitation on cost sharing means the dollar value of the maximum annual limitation on cost sharing for a silver plan variation that remains after applying the reduction, if any, in the maximum annual limitation on cost sharing required by section 1402 of the Affordable Care Act as announced in the annual HHS notice of benefit and payment parameters.

Silver plan variation means, with respect to a standard silver plan, any of the variations of that standard silver plan described in § 156.420(a).