DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Parts 146, 147, 148, 153, 155, 156, and 158

[CMS–9949–P]

RIN 0938–AS02

Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Proposed rule.

SUMMARY: This proposed rule addresses various requirements applicable to health insurance issuers, Affordable Insurance Exchanges (''Exchanges''), Navigators, non-Navigator assistance personnel, and other entities under the Patient Protection and Affordable Care Act and the Health Care and Education Reconciliation Act of 2010 (collectively referred to as the Affordable Care Act). Specifically, the rule proposes standards related to product discontinuation and renewal, quality reporting, non-discrimination standards, minimum certification standards and responsibilities of qualified health plan (QHP) issuers, the Small Business Health Options Program, and enforcement remedies in Federally-facilitated Exchanges. It also proposes: A modification of HHS's allocation of reinsurance contributions collected if those contributions do not meet our projections; certain changes to the ceiling on allowable administrative expenses in the risk corridors calculation; modifications to the way we calculate certain cost-sharing parameters so that we round those parameters down to the nearest $50 increment; certain approaches we are considering to index the required contribution used to determine eligibility for an exemption from the shared responsibility payment under section 5000A of the Internal Revenue Code; grounds for imposing civil money penalties on persons who provide false or fraudulent information to the Exchange and on persons who improperly use or disclose information; updated standards for the consumer assistance programs; standards related to the opt-out provisions for self-funded, non-Federal governmental plans and the individual market provisions under the Health Insurance Portability and Accountability Act of 1996; standards for recognition of certain types of foreign group health coverage as minimum essential coverage; amendments to Exchange appeals standards and coverage enrollment and termination standards; and time-limited adjustments to the standards relating to the medical loss ratio program.

DATES: To be assured consideration, comments must be received at one of the addresses provided below no later than 5 p.m. on April 21, 2014.

ADDRESSES: In commenting, please refer to file code CMS–9949–P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the ''Submit a comment'' instructions.

2. *By regular mail.* You may mail written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9949–P, P.O. Box 8016, Baltimore, MD 21244–8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address ONLY: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Attention: CMS–9949–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* Alternatively, you may deliver (by hand or courier) your written comments ONLY to the following addresses prior to the close of the comment period:

a. For delivery in Washington, DC—Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification, commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD—Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments erroneously mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT: For general matters and matters related to Parts 146 through 148: Jacob Ackerman, (301) 492–4179.

For matters related to reinsurance, under Part 153: Adrianne Glasgow, (410) 786–0686.

For matters related to risk corridors, under Part 153: Jaya Ghildiyal, (301) 492–5149.

For matters related to non-interference with Federal law and non-discrimination standards, and Navigator, non-Navigator assistance personnel, and certified application counselor program standards, under Part 155, subparts B and C: Joan Matlack, (301) 492–4223.

For matters related to civil money penalties and consumer authorization forms, under Part 155, subpart C: Emily Ames, (301) 492–4246.

For matters related to civil money penalties for false or fraudulent information or improper use of information, under Part 155, subpart C: Julia Cassidy, (301) 492–4412.

For matters related to enrollment of a qualified individual, under Part 155, subpart E: Jack Lavelle, (410) 786–0639.

For matters related to special enrollment periods and exemptions under Part 155, subparts D and G, and matters related to eligibility appeals, under Part 155, subparts F and H: Christine Hammer, (301) 492–4431.

For matters related to the Small Business Health Options Program, under Part 155, subpart H: Christelle Jang, (410) 786–8438.

For matters related to the required contribution percentage for affordability exemptions, under Part 155, subpart G: Ariel Novick, (301) 492–4309.

For matters related to cost sharing, under Part 156, subpart B: Pat Meisol, (410) 786–1917.

For matters related to quality standards, under Parts 155 and 156: Nidhi Singh Shah, (301) 492–5110.

For matters related to minimum essential coverage, under Part 156, subpart G: Cam Clemmons, (410) 786–1565.

For all other matters related to Parts 155 and 156: Leigha Basini, (301) 492–4380.

For matters related to the medical loss ratio program, under Part 158: Julie McCune, (301) 492–4196.

SUPPLEMENTARY INFORMATION:

Electronic Access

This **Federal Register** document is also available from the **Federal Register** online database through *Federal Digital System (FDsys),* a service of the U.S. Government Printing Office. This database can be accessed via the internet at *http://www.gpo.gov/fdsys.*

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Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1–800–743–3951.

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Abbreviations

Affordable Care Act The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)
AV Actuarial Value
CAC Certified Application Counselor
CAHPS® Consumer Assessment of Healthcare Providers and Systems
CFR Code of Federal Regulations
CMP Civil Money Penalty
CMS Centers for Medicare & Medicaid Services
CSR Cost-Sharing Reductions
DSH Disproportionate Share Hospital
EHB Essential Health Benefits
ERISA Employee Retirement Income Security Act of 1974 (Pub. L. 93–406)
ESS Enrollee Satisfaction Survey
FFE Federally-facilitated Exchange
FF–SHOP Federally-facilitated Small Business Health Options Program
FQHC Federally Qualified Health Center
HHS United States Department of Health and Human Services
HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)
IRS Internal Revenue Service
MLR Medical Loss Ratio
NAIC National Association of Insurance Commissioners
OMB Office of Management and Budget
OPM United States Office of Personnel Management
PHS Act Public Health Service Act
PRA Paperwork Reduction Act of 1995
PSO Patient Safety Organization
QHP Qualified health plan
QRS Quality Rating System
SHOP Small Business Health Options Program
The Code Internal Revenue Code of 1986
URL Uniform Resource Locator

I. Executive Summary

Since January 1, 2014, qualified individuals and small employers have been able to obtain private health insurance through Affordable Insurance Exchanges, or ''Exchanges'' (also known as Health Insurance Marketplaces, or ''Marketplaces'').[1] The Exchanges provide competitive marketplaces where individuals and small employers can compare available private health insurance options on the basis of price, quality, and other factors. The Exchanges help enhance competition in the health insurance market, improve choice of affordable health insurance, and give small businesses the same purchasing power as large businesses.

Individuals who enroll in qualified health plans (QHPs) through individual market Exchanges may be eligible to receive premium tax credits to make health insurance purchased through an Exchange more affordable and cost-sharing reductions that lower out-of-pocket expenses for health care services. The premium tax credits, combined with the new insurance reforms, will significantly increase the number of individuals with health insurance coverage. Premium stabilization programs—risk adjustment, reinsurance, and risk corridors—protect against adverse selection in the newly enrolled population. These programs, in combination with the medical loss ratio program and market reforms extending guaranteed availability (also known as guaranteed issue) protections, prohibiting the use of factors such as health status, medical history, gender, and industry of employment to set premium rates, will help to ensure that every American has access to high quality, affordable health insurance.

This proposed rule would address various requirements applicable to health insurance issuers, Exchanges, Navigators, non-Navigator assistance personnel, and other entities under the Affordable Care Act. Specifically, the rule proposes standards related to product discontinuation and renewal, quality reporting, non-discrimination standards, minimum certification standards and responsibilities of qualified health plan (QHP) issuers, the Small Business Health Options Program, and enforcement remedies in Federally-facilitated Exchanges. It also proposes: A modification of HHS's allocation of reinsurance contributions collected if those contributions do not meet our projections; certain changes to the ceiling on allowable administrative expenses in the risk corridors calculation; modifications to the way we calculate certain cost-sharing parameters so that we round those parameters down to the nearest $50 increment; certain approaches we are considering to index the required contribution used to determine eligibility for an exemption from the shared responsibility payment under section 5000A of the Internal Revenue Code; grounds for imposing civil money penalties on persons who provide false or fraudulent information to the Exchange and on persons who improperly use or disclose information; updated standards for the consumer assistance programs; standards related to the opt-out provisions for self-funded, non-Federal governmental plans and the individual market provisions under the Health Insurance Portability and Accountability Act of 1996; standards for recognition of certain types of foreign group health coverage as minimum essential coverage; amendments to Exchange appeals standards and coverage enrollment and termination standards; and time-limited adjustments to the standards relating to the medical loss ratio program. Nearly all of these proposed policies were described in the preamble to the final rule titled, HHS Notice of Benefit and Payment Parameters for 2015, published on March 11, 2014 (79 FR 13744) (2015 Payment Notice).[2]

Product Withdrawal and Uniform Modification of Coverage Exceptions to Guaranteed Renewability Requirements: Under sections 2702 and 2703 of the Public Health Service Act (PHS Act), as added by the Affordable Care Act, health insurance issuers in the group and individual markets must guarantee the availability and renewability of coverage unless an exception applies. In this proposed rule, we propose criteria for determining when modifications made by an issuer to the health insurance coverage for a product would and would not constitute the discontinuation of an existing product and the creation of a new product. We also propose that issuers use standard consumer notices in a format designated by the Secretary when discontinuing or renewing a product in the group or

[1] The word ''Exchanges'' refers to both State Exchanges, also called State-based Exchanges, and Federally-facilitated Exchanges (FFEs). In this proposed rule, we use the terms ''State Exchange'' or ''FFE'' when we are referring to a particular type of Exchange. When we refer to ''FFEs,'' we are also referring to State Partnership Exchanges, which are a form of FFEs.

[2] Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015, 79 FR 13744 (March 11, 2014).

individual market. Additionally, we propose to clarify that the guaranteed availability and renewability requirements should not be construed to supersede other provisions of Federal law in certain circumstances.

Conforming Changes to Individual Market Provisions: Sections 2741 through 2744 of the PHS Act were added by HIPAA to improve the portability and continuity of coverage in the individual health insurance market. These provisions are implemented through regulations in 45 CFR Part 148. In this proposed rule, we propose to amend the individual market provisions in Part 148 to reflect the amendments made by the Affordable Care Act. These amendments are for clarity only.

Fixed Indemnity Insurance in the Individual Market: Consistent with previously released guidance, we propose to amend the criteria for fixed indemnity insurance to be treated as an excepted benefit in the individual health insurance market.[3] The proposed amendments would eliminate the requirement that individual fixed indemnity insurance must pay on a per-period basis (as opposed to a per-service basis), and instead require, among other things, that it be sold only as secondary to other health coverage that is minimum essential coverage to be considered an excepted benefit.

HIPAA Opt-Out for Self-Funded, Non-Federal Governmental Plans: Prior to enactment of the Affordable Care Act, sponsors of self-funded, non-Federal governmental plans were permitted to elect to exempt those plans from (''opt out of'') certain provisions of title XXVII of the PHS Act. Consistent with previously released guidance, we propose amendments to the non-Federal governmental plan regulations (45 CFR 146.180) to reflect the amendments made by the Affordable Care Act to these provisions.[4]

Premium Stabilization Programs: The Affordable Care Act establishes three premium stabilization programs—risk adjustment, reinsurance, and risk corridors—to protect against adverse selection. The goal of the permanent risk adjustment program is to mitigate the impacts of possible adverse selection and stabilize the premiums in the individual and small group markets as and after insurance market reforms are implemented. The Affordable Care Act also directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage by helping to pay the cost of treating high-cost enrollees in the individual market from 2014 through 2016.

Both the reinsurance and risk adjustment programs are subject to the fiscal year 2015 sequestration. The risk adjustment and reinsurance programs will be sequestered at a rate of 7.3 percent in fiscal year 2015. The Federal government's 2015 fiscal year begins on October 1, 2014. HHS, in coordination with the OMB, has determined that, pursuant to section 256(k)(6) of the Balanced Budget and Emergency Deficit Control Act of 1985 as amended, and the underlying authority for these programs, funds that are sequestered in fiscal year 2015 from the reinsurance and risk adjustment programs will become available for payment to issuers in fiscal year 2016 without further Congressional action. HHS is still working through operational questions regarding the structure and timing of these payments, but aims to make payments of sequestered fiscal year 2015 funding for the reinsurance and risk adjustment programs, which would have otherwise been paid in the summer of 2015, as soon as practicably possible in fiscal year 2016, which begins on October 1, 2015. Should Congress fail to enact deficit reduction that replaces the Joint Committee reductions, these programs would be sequestered in future fiscal years, and any sequestered funding would become available in the fiscal year following that in which it was sequestered.

In this proposed rule, we solicit feedback on potential revisions to the allocation of reinsurance contributions collected and we suggest an approach such that the contributions collected under that program are allocated first to the reinsurance pool and administrative expenses, and second to the U.S. Treasury. In addition, we invite comment on alternative allocation approaches to maximize the premium stabilization benefits of the program.

We also propose changing the limit on allowable administrative costs to 22 percent and the limit on profits to 5 percent in the risk corridors calculation, in recognition of the ongoing uncertainty and changes in the market in 2015; we expect to implement this change in a budget neutral way.

Exchange Establishment and QHP Issuer Standards: The rule proposes amending oversight standards regarding QHP decertification and CMPs. It also proposes that QHP issuers provide enrollees with an annual notice of coverage changes. This rule proposes a process for survey vendors to appeal an HHS decision not to approve its application to become an enrollee satisfaction survey (ESS) vendor, as well as standards for revoking HHS-approval of ESS vendors. Finally, it proposes standards for the ESS and quality rating system (QRS) related to the display of such information by Exchanges and the submission of validated data by QHP issuers.

We propose to align the start of annual employer election periods in all SHOPs for plan years beginning in 2015 with the start of open enrollment in the corresponding individual market Exchange for the 2015 benefit year and to eliminate the 30-day minimum time frames for the employer and employee annual election periods. We also propose to allow State departments of insurance to recommend that, in 2015, a SHOP not provide employers with the option of selecting a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, and making all QHPs at that level of coverage available to their employees if making that option available would result in significant adverse selection in the State's small group market resulting in market disruptions that could not be addressed by the premium stabilization programs or single risk pool, or if there would be insufficient issuers of qualified health plans or qualified stand-alone dental plans to allow for meaningful choice among plans. We propose to allow the opportunity for a person appealing a determination of SHOP eligibility to withdraw an appeal by telephone, if the appeals entity is capable of accepting telephonic signatures.

Civil Money Penalties for False Information or Improper Use of Information: The proposed rule specifies the grounds for imposing civil money penalties on persons who provide false or fraudulent information to the Exchange and on persons who use or disclose information in violation of section 1411(g) of the Affordable Care Act. The grounds for imposing a penalty include: negligent failure to provide correct information, knowing and willful provision of false or fraudulent information, and knowing and willful use or disclosure of information in violation of section 1411(g). This section proposes the factors used to determine the amount of the CMP to be imposed against a person. The section also provides for the requirements for notices which must be provided to a

[3] FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, Q11 (January 9, 2014). Available at: *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html* and *http://www.dol.gov/ebsa/faqs/faq-aca18.html.*

[4] Amendments to the HIPAA opt-out provision (formerly section 2721(b)(2) of the Public Health Service Act) made by the Affordable Care Act (September 21, 2010). Available at: *http://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf.*

person if HHS proposes to impose a CMP, and the processes a person may follow should the person wish to challenge HHS' determination that a CMP should be imposed, including a process pursuant to which a person may request a hearing before an administrative law judge. We also propose to amend current privacy and security regulations at 45 CFR 155.260 to reference the new CMP provisions associated with knowingly and willfully using or disclosing information in violation of section 1411(g) of the Affordable Care Act.

Civil Money Penalties for Consumer Assistance Entities: The proposed rule would provide that HHS may impose CMPs against Navigators, non-Navigator assistance personnel, certified application counselor designated organizations, and certified application counselors in FFEs, if these entities and/or individuals violate Federal requirements applicable to their activities.

Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards: In this proposed rule, we propose to specify certain types of State laws applicable to Navigators, non-Navigator assistance personnel, and certified application counselors that HHS considers to conflict with or prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. We would also make several changes to update the standards applicable to these consumer assistance entities and individuals, such as prohibiting them from specified marketing or solicitation activities. We propose to require Navigators and non-Navigator assistance personnel to obtain authorization before accessing a consumer's personally identifiable information and to prohibit them from charging consumers for their services. We also propose to require that certified application counselors be recertified on at least an annual basis, and propose to prohibit certified application counselors and certified application counselor designated organizations from receiving consideration, directly or indirectly, from health insurance issuers or stop loss insurance issuers in connection with the enrollment of consumers in QHPs or non-QHPs. We further propose that, in specific circumstances, certified application counselor designated organizations can serve targeted populations without violating the broad non-discrimination requirement related to Exchange functions.

Indexing of Cost-Sharing Requirements: Under § 156.130(a), the annual limitation on cost sharing and the annual limitation on deductibles in the small group market for years after 2014 are to be indexed by the premium adjustment percentage. We established our methodology for calculating the premium adjustment percentage in the 2015 Payment Notice. In this rule, we propose calculating these limitations based on the premium adjustment percentage by rounding down to the nearest $50 increment.

Required Contribution Percentage: Under section 5000A of the Code, an applicable individual must maintain minimum essential coverage for each month, qualify for an exemption, or make a shared responsibility payment. An individual may qualify for an exemption from the shared responsibility payment if the amount that he or she would be required to pay towards minimum essential coverage (required contribution) exceeds a particular percentage (the required contribution percentage) of his or her household income. Under section 5000A of the Code, the required contribution percentage for 2014 is 8 percent, and for each plan year beginning in a calendar year after 2014, the percentage, as determined by the Secretary of Health and Human Services (the Secretary), that reflects the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for the same period. In this preamble to this proposed rule, we describe issues related to possible methodologies for determining the percentage reflecting the excess of the rate of premium growth over the rate of income growth for plan years after 2014.

Eligibility Appeals: This rule proposes to amend standards related to eligibility appeals provisions in subparts F and H of Part 155. To facilitate the efficient conclusion of an appeal at the request of the appellant, we propose to amend the withdrawal procedure to permit withdrawals made via telephonic signature.

Minimum Essential Coverage: On October 31, 2013, we published guidance indicating that certain types of foreign group health coverage are recognized as minimum essential coverage.[5] In this proposed rule, we propose amendments codifying the treatment of foreign group coverage as described in the October 31, 2013 guidance. We also clarify that entities other than plan sponsors (for example, issuers) can apply for their coverage to be recognized as minimum essential coverage, pursuant to the process outlined in 45 CFR 156.604 and guidance thereunder.

Medical Loss Ratio: The MLR program created pursuant to the Affordable Care Act generally requires issuers to rebate a portion of premiums if their MLR fails to meet the applicable MLR standard in a State and market for the applicable reporting year. An issuer's MLR is the ratio of claims plus quality improvement activities to premium revenue, with the premium adjusted by the amounts paid for taxes, licensing and regulatory fees, and the premium stabilization programs. On December 1, 2010, we published an interim final rule entitled ''Health Insurance Issuers Implementing Medical Loss Ratio (MLR) Requirements under the Patient Protection and Affordable Care Act'' (75 FR 74864), which established standards for the MLR program. Since then, we have made several revisions and technical corrections to those rules. In this proposed rule, we propose to modify the timeframe for which issuers can include their ICD–10 conversion costs in their MLR calculation. We also propose to modify the regulation to clarify how issuers would calculate MLRs and rebates in States that require the individual and small group markets to be merged. We note that the standards for ICD–10 conversion costs and merged markets would also apply to the risk corridors program. Further, we propose to modify the regulation to account for the special circumstances of the issuers affected by the CMS November 2013 transitional policy and the issuers impacted by systems challenges during the implementation of the Exchanges. We also propose to amend the requirements for distribution of *de minimis* rebates.

II. Background

A. Legislative Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148) was enacted on March 23, 2010. The Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152), which amended and revised several provisions of the Patient Protection and Affordable Care Act, was enacted on March 30, 2010. In this proposed rule, we refer to the two statutes collectively as the ''Affordable Care Act.''

The Affordable Care Act reorganizes, amends, and adds to the provisions of title XXVII of the PHS Act relating to group health plans and health insurance

[5] See CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (October 31, 2013). Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf.*

issuers in the group and individual markets.

Section 1201 of the Affordable Care Act added sections 2702 and 2703 of the PHS Act. Section 2702 of the PHS Act generally requires an issuer that offers health insurance coverage in the individual or group market in a State to offer coverage to and accept every individual or employer in the State that applies for such coverage. Section 2703 of the PHS Act generally requires an issuer to renew or continue in force coverage in the group or individual market at the option of the plan sponsor or the individual.

Prior to enactment of the Affordable Care Act, HIPAA amended the PHS Act to improve access to individual health insurance coverage for certain eligible individuals who previously had group coverage, and to guarantee the renewability of all coverage in the individual market. These reforms were added as sections 2741 through 2744 of the PHS Act.

HIPAA also added PHS Act provisions permitting sponsors of self-funded, non-Federal governmental plans to elect to exempt those plans from (''opt out of'') certain provisions of title XXVII of the PHS Act. This election was authorized under section 2721(b)(2) of the PHS Act, which is now designated as section 2722(a)(2) of the PHS Act by the Affordable Care Act.

Section 2718 of the PHS Act, as added by the Affordable Care Act, generally requires health insurance issuers to submit an annual MLR report to HHS and provide rebates to consumers if they do not achieve specified MLRs.

Sections 2722 and 2763 of the PHS Act, as implemented in 45 CFR 146.145(b) and 148.220, provide that the requirements of parts A and B of title XXVII of the PHS Act shall not apply to any individual coverage or any group health plan (or group health insurance coverage) in relation to its provision of excepted benefits. Excepted benefits are described in section 2791(c) of the PHS Act. One category of excepted benefits, called ''noncoordinated excepted benefits,'' includes coverage for only a specified disease or illness, and hospital indemnity or other fixed indemnity insurance. Benefits in this category are excepted only if they meet certain conditions specified in the statute and regulations.

Section 1302(c) of the Affordable Care Act establishes an annual limitation on cost sharing and an annual limitation on deductibles in the small group market for 2014, and provides that those limitations are to be increased for each year after 2014 by the percentage by which the average per capita premium for health insurance coverage in the United States for the preceding year exceeds the average per capita premium for 2013. Under section 1302(c), those limitations are to be rounded to the next lowest multiple of $50.

Section 1311(b) of the Affordable Care Act provides that each State has the opportunity to establish an Exchange that: (1) Facilitates the purchase of insurance coverage by qualified individuals through QHPs; (2) provides for the establishment of a SHOP designed to assist qualified employers in the enrollment of their qualified employees in QHPs; and (3) meets other requirements specified in the Affordable Care Act.

Section 1311(c)(3) of the Affordable Care Act requires the Secretary to develop a rating system to rate QHPs offered through an Exchange on the basis of quality and price. Section 1311(c)(4) of the Affordable Care Act directs the Secretary to establish an ESS system that would evaluate the level of enrollee satisfaction of members in QHPs offered through an Exchange, for each QHP with more than 500 enrollees in the previous year. Sections 1311(c)(3) and 1311(c)(4) of the Affordable Care Act further require an Exchange to provide information to individuals and employers from the rating and ESS systems on the Exchange's Web site. We have already promulgated regulations in 45 CFR 155.200(d) that direct Exchanges to oversee implementation of ESSs and ratings of health care quality and outcomes, and 45 CFR 156.200(b)(5) [6] that directs QHP issuers that participate in Exchanges to report health care quality and outcomes information and to implement an ESS consistent with the Affordable Care Act.

Sections 1311(d)(4)(K) and 1311(i) of the Affordable Care Act direct all Exchanges to establish a Navigator program.

Section 1321(a) of the Affordable Care Act provides broad authority for the Secretary to establish standards and regulations to implement the statutory requirements related to Exchanges, QHPs and other components of title I of the Affordable Care Act. Section 1321(a)(1) directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act with respect to, among other things, the establishment and operation of Exchanges. Section 1321(a)(2) requires the Secretary to engage in consultation to ensure balanced representation among interested parties.

Section 1321 of the Affordable Care Act provides for State flexibility in the operation and enforcement of Exchanges and related requirements. Section 1321(d) provides that nothing in title I of the Affordable Care Act shall be construed to preempt any State law that does not prevent the application of title I of the Affordable Care Act. Section 1311(k) specifies that Exchanges may not establish rules that conflict with or prevent the application of regulations promulgated by the Secretary.

Section 1321(c)(1) requires the Secretary of HHS (referred to throughout this rule as the Secretary) to establish and operate an FFE within States that either: (1) Did not elect to establish an Exchange; or (2) as determined by the Secretary, did not have any required Exchange operational by January 1, 2014.

Section 1321(c)(2) of the Affordable Care Act provides that the provisions of section 2723(b) of the PHS Act [7] shall apply to the enforcement under section 1321(c)(1) of requirements of section 1321(a)(1), without regard to any limitation on the application of those provisions to group health plans. Section 2723(b) of the PHS Act authorizes the Secretary to impose CMPs as a means of enforcing the individual and group market reforms contained in Part A of title XXVII of the PHS Act when, in the Secretary's determination, a State fails to substantially enforce these provisions.

Section 1341 of the Affordable Care Act requires the establishment of a transitional reinsurance program in each State to help pay the cost of treating high-cost enrollees in the individual market from 2014 through 2016. Section 1342 of the Affordable Care Act directs the Secretary to establish a temporary risk corridors program that provides for the sharing in gains or losses resulting from inaccurate rate setting from 2014 through 2016 between the Federal government and certain participating health plans.

Section 1411(f)(1) of the Affordable Care Act provides that the Secretary, in consultation with the Secretary of the Treasury, the Secretary of Homeland Security, and the Commissioner of Social Security, shall establish procedures by which the Secretary or one of such other Federal officers hears and makes decisions with respect to

[6] Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers; Final Rule, 77 FR 18310 (Mar. 27, 2012) (to be codified at 45 CFR parts 155, 156, & 157).

[7] Section 1321(c) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act. This was clearly a typographical error, and we have interpreted section 1321(c) of the Affordable Care Act to incorporate section 2723(b) of the PHS Act.

appeals of any determination under subsection (e) and redetermines eligibility on a periodic basis in appropriate circumstances. Section 1411(f)(2) of the Affordable Care Act provides that the Secretary shall establish a separate appeals process for employers who are notified under section 1411(e)(4)(C) of the Affordable Care Act that the employer may be liable for a tax imposed by section 4980H of the Internal Revenue Code of 1986 (the Code) with respect to an employee because of a determination that the employer does not provide minimum essential coverage through an employer-sponsored plan or that the employer does provide that coverage but it is not affordable coverage with respect to an employee.

Section 1411(h) of the Affordable Care Act sets forth CMPs to which any person may be subject if that person provides inaccurate information as part of an Exchange application or improperly uses or discloses an applicant's information.

Section 1501(b) of the Affordable Care Act added section 5000A to the Code. That section, as amended by the TRICARE Affirmation Act of 2010 (Pub. L. 111–159, 124 Stat. 1123) and Public Law 111–173 (124 Stat. 1215), requires nonexempt individuals to either maintain minimum essential coverage or make a shared responsibility payment for each month beginning in 2014. It also describes categories of individuals who may qualify for an exemption from the individual shared responsibility payment. Section 1311(d)(4)(H) of the Affordable Care Act specifies that the Exchange will, subject to section 1411 of the Affordable Care Act, grant certifications of exemption from the individual shared responsibility payment specified in section 5000A of the Code. Standards relating to these provisions were established in IRS regulations titled, Shared Responsibility Payment for Not Maintaining Minimum Essential Coverage Final Rule published in the August 30, 2013 **Federal Register** (78 FR 53646) (IRS Minimum Essential Coverage Final Rule) and HHS regulations titled, Exchange Functions: Eligibility for Exemptions; Miscellaneous Minimum Essential Coverage Provisions Final Rule published in the July 1, 2013 **Federal Register** (78 FR 39494) (HHS Minimum Essential Coverage Final Rule).

B. Stakeholder Consultation and Input

HHS has consulted with stakeholders on policies related to the operation of Exchanges, including the SHOP and the premium stabilization programs. HHS has held a number of listening sessions with consumers, providers, employers, health plans, the actuarial community, and State representatives to gather public input. HHS consulted with stakeholders through regular meetings with the National Association of Insurance Commissioners (NAIC), regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes, technical health care quality measurement experts, health care survey development experts, and meetings with Tribal leaders and representatives, health insurance issuers, trade groups, consumer advocates, employers, and other interested parties. In addition, HHS received public comment on various notices published in the **Federal Register** relating to health care quality in the Exchanges,[8] enrollee experience measures and domains,[9] and the quality rating system, which provided valuable feedback on quality reporting and quality rating requirements.[10] We considered all of the public input as we developed the policies in this proposed rule.

C. Structure of Proposed Rule

The regulations outlined in this proposed rule would be codified in 45 CFR parts 146, 147, 148, 153, 155, 156, and 158. Part 146 outlines the group health insurance market requirements of the PHS Act added by HIPAA and other laws, including guaranteed renewability standards and opt-out provisions for sponsors of self-funded, non-Federal governmental plans. Part 147 outlines health insurance reform requirements for the group and individual markets added by the Affordable Care Act, including standards related to guaranteed availability and guaranteed renewability of coverage. Part 148 outlines the individual health insurance market requirements of the PHS Act added by HIPAA and other laws, including standards related to guaranteed availability with respect to certain eligible individuals and guaranteed renewability for all individuals. Part 153 outlines standards related to reinsurance program and risk corridors programs. Part 155 outlines standards related to the operations and functions of an Exchange, including standards related to non-discrimination, accessibility, and enforcement remedies; standards applicable to the consumer assistance functions performed by Navigators, non-Navigator assistance personnel, and certified application counselors; standards related to eligibility appeals; standards related to exemptions; standards related to quality reporting; and standards related to SHOP. Part 156 outlines health insurance issuer responsibilities, including the methodology for calculating the annual limit on cost-sharing and deductibles for years after 2014; minimum certification standards; standards for recognition of certain types of foreign group health coverage as minimum essential coverage; quality standards for QHPs; and other QHP issuer responsibilities. Part 158 outlines standards related to the medical loss ratio program, including standards related to treatment of ICD–10 conversion costs, standards related to adjustments for issuers affected by the November 2013 CMS transitional policy and issuers that incurred costs due to the technical problems during the implementation of the Exchanges, standards related to MLR reporting and rebate calculations in States with merged individual and small group markets, and standards related to distribution of *de minimis* rebates.

III. Provisions of the Proposed Rule

A. Part 146—Requirements for the Group Health Insurance Market

1. HIPAA Opt-Out Provisions for Plan Sponsors of Self-Funded, Non-Federal Governmental Plans (§ 146.180)

Prior to enactment of the Affordable Care Act, sponsors of self-funded, non-Federal governmental plans were permitted to elect to exempt those plans from (''opt out of'') certain provisions of title XXVII of the PHS Act. This election was authorized under section 2721(b)(2) of the PHS Act. Sponsors of those plans could elect to opt out of all or any of the following title XXVII requirement categories:

1. Limitations on preexisting condition exclusion periods under section 2701 of the PHS Act (redesignated as section 2704 by the Affordable Care Act).

2. Requirements for special enrollment periods under section 2701 of the PHS Act (redesignated as section 2704 by the Affordable Care Act).

3. Prohibitions against discriminating against individual participants and beneficiaries based on health status (but

[8] Request for Information Regarding Health Care Quality for Exchanges: *http://www.gpo.gov/fdsys/pkg/FR-2012-11-27/pdf/2012-28473.pdf*.

[9] Request for Domains, Instruments, and Measures for Development of a Standardized Instrument for Use in Public Reporting of Enrollee Satisfaction With Their Qualified Health Plan and Exchange: *http://www.gpo.gov/fdsys/pkg/FR-2012-06-21/html/2012-15162.htm*.

[10] Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS) Framework, Measures and Methodology; Notice with Comment, 78 FR 69418 (Nov. 19, 2013).

not including provisions added by the Genetic Information Nondiscrimination Act of 2008) under 2702 of the PHS Act (redesignated as section 2705 by the Affordable Care Act).

4. Standards relating to benefits for newborns and mothers under section 2704 of the PHS Act (redesignated as section 2725 by the Affordable Care Act).

5. Parity in the application of certain limits to mental health and substance use disorder benefits (including requirements of the Mental Health Parity and Addiction Equity Act of 2008) under section 2705 of the PHS Act (redesignated as section 2726 by the Affordable Care Act).

6. Required coverage for reconstructive surgery following mastectomies under section 2706 of the PHS Act (redesignated as section 2727 of the PHS Act).

7. Coverage of dependent students on a medically necessary leave of absence under section 2707 of the PHS Act (redesignated as section 2728 by the Affordable Care Act).

The Affordable Care Act made a number of changes, with the result that sponsors of self-funded, non-Federal governmental plans can no longer opt out of as many requirements of title XXVII. First, PHS Act section 2721 was redesignated as section 2722. The new section 2722(a)(2) no longer allows a sponsor of a self-funded, non-Federal governmental plan to exempt that plan from the first 3 requirement categories listed above, but may continue to exempt the plan from requirement categories 4 through 7.

In response to the Affordable Care Act amendments, HHS issued guidance on September 21, 2010 indicating that, for plan years beginning on or after September 23, 2010, plan sponsors of non-collectively bargained plans can only elect to be exempt from provisions 4–7 and that provisions 1–3 are no longer available for exemption.[11] Group health plans maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010, and that has been exempted from any of the first 3 requirement categories listed above, would not have to come into compliance with those provisions until the commencement of the first plan year following the expiration of the last plan year governed by the collective bargaining agreement. Because of the timing of the guidance, HHS elected not to take any enforcement actions with respect to opt-out elections for plan years beginning prior to April 1, 2011 on the provisions 1–3.

We propose to revise the provisions of § 146.180 to reflect the amendments of the Affordable Care Act and the September 21, 2010 guidance. While the proposed rule restates the current rule in the procedures for filing an opt-out election with CMS, the following revisions are being proposed primarily to reflect the Affordable Care Act amendments: identification of PHS Act provisions subject to the opt-out election as noted above; deletion of references to the notice of creditable coverage requirement since that requirement has been superseded; and the deletion of examples referencing provisions that are no longer available for opt-out elections.

Additionally, we propose to replace the address for submitting the election documents with language indicating that opt-out elections must be submitted in an electronic format as specified by the Secretary in guidance. We believe that electronic submissions will be easier and more efficient for both the plan sponsors and for CMS to track the submissions. We welcome comments on improving the election process in order for elections to be submitted electronically. Until the issuance of final regulations, elections will be accepted via U.S. Mail or facsimile. The current address for the submission, as noted on the CMS/CCIIO Web site, is Centers for Medicare & Medicaid Services (CMS), Center for Consumer Information and Insurance Oversight (CCIIO), Attn: HIPAA Opt-Out, 200 Independence Avenue SW., Room 733H–02, Washington, DC 20201. Elections can also be submitted via facsimile at 301–492–4462. Questions regarding the opt-out process can be submitted to CMS at *HIPAAOptOut@cms.hhs.gov*. CMS makes publicly available on its Web site a list of self-funded, non-Federal governmental plans that have submitted an opt-out election and the PHS Act provisions subject to the election.[12]

The proposed rule would clarify that plan sponsors of self-funded, non-Federal governmental plans offering health coverage subject to a collectively bargained agreement that was ratified before March 23, 2010 can continue to be exempt from any of the 7 original provisions for which a timely election was filed with CMS until the expiration of the last plan year subject to the agreement.

These proposed amendments would generally become applicable upon the effective date of the final rule. Comments are welcome on the proposed revisions and on any aspect of the proposed rule, including the provisions unchanged from the current regulation.

Finally, we note that some plan administrators have been submitting one opt-out election to CMS for multiple group health plans. While this is permitted for plans subject to the same collective bargaining agreement, single elections have been received for multiple plans not under a collective bargaining agreement. The current regulations expressly require a separate election for each group health plan not subject to collective bargaining. We request comments on whether the regulation should be modified to allow a single opt-out submission for multiple group health plans not subject to collective bargaining. We are also considering requiring, as part of the opt-out election document, that sponsors of plans subject to a collective bargaining agreement be required to list all plans subject to the agreement. We welcome comments on this proposal.

B. Part 147—Health Insurance Reform Requirements for the Group and Individual Health Insurance Markets

1. Guaranteed Availability and Guaranteed Renewability of Coverage (§§ 147.104 and 147.106)

a. No Effect on Other Laws

Section 2702 of the PHS Act generally requires a health insurance issuer that offers health insurance coverage in the individual or group market in a State to offer coverage to and accept every individual or employer in the State that applies for coverage. Section 2703 of the PHS Act generally requires a health insurance issuer to renew or continue in force[13] coverage in the group or individual market at the option of the plan sponsor or the individual. These sections are implemented by regulations at 45 CFR 147.104 and 147.106, respectively. They apply to health plans offered both through and outside of an Exchange.

There are several exceptions to these requirements. In addition to statutorily specified exceptions set forth in sections 2702 and 2703 of the PHS Act, other Federal laws restrict the products that are available to certain individuals. For example, section 1882(d) of the Social

[11] Amendments to the HIPAA opt-out provision (formerly section 2721(b)(2) of the Public Health Service Act) made by the Affordable Care Act (September 21, 2010). Available at: *http://www.cms.gov/CCIIO/Resources/Files/Downloads/opt_out_memo.pdf*.

[12] *See* List of HIPAA Opt-Out Elections for Self-Funded Non-Federal Governmental Plans. Available at: *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa-nfgp-list-7-9-2013.pdf*.

[13] ''Continue in force'' means that the issuer maintains the same policy form that the plan sponsor or individual purchased.

Security Act establishes an anti-duplication provision that makes it unlawful for an issuer to knowingly sell to an individual entitled to benefits under Medicare part A or enrolled under Medicare part B an individual health insurance policy that duplicates Medicare benefits; sections 1311(d)(2) and 1312(f) of the Affordable Care Act limit access of an individual market QHP offered through an Exchange to citizens and lawful residents; [14] and section 1302(e) of the Affordable Care Act provides that only individuals under age 30, and individuals who are certified as exempt from the requirement to maintain minimum essential coverage based on lack of affordable coverage or hardship, are eligible to enroll in catastrophic plans. Consistent with the canons of statutory construction, which provide that specific statutory language ordinarily trumps conflicting general language,[15] the guaranteed availability and renewability requirements are subordinated to these and other Federal law requirements limiting access to coverage. As a result, issuers of coverage subject to specific Federal statutes that conflict with PHS Act sections 2702 and 2703 could deny enrollment or reenrollment in coverage where doing otherwise is contrary to law.

We propose to amend the guaranteed availability and renewability regulations to codify this interpretation in regulation text. We propose to add new paragraph (h) in § 147.104 providing that nothing in the guaranteed availability requirements should be construed to require an issuer to offer coverage where other Federal laws operate to prohibit the issuance of such coverage. Similarly, we propose to redesignate paragraphs (g) and (h) as (h) and (i), and add new paragraph (g) in § 147.106 providing that nothing in the guaranteed renewability requirements should be construed to require an issuer to renew or continue in force coverage for which continued eligibility would otherwise be prohibited under applicable Federal law. We believe that these regulatory changes are consistent with current market practice and will cause no disruption in the health insurance market. We solicit comment on these and other clarifications that may be helpful. We note that only Federal laws, not State laws, can create exceptions to the Federal guaranteed availability and renewability requirements.

We also note that, due to a formatting error in the interim final rule with comment period titled, Patient Protection and Affordable Care Act; Maximizing January 1, 2014 Coverage Opportunities (78 FR 76212), the regulation text at § 147.104(b)(1)(i) contains a duplicate reference to the SHOP regulation at § 155.725. We propose to correct the duplicate reference in this proposed rule, and to make other minor regulatory revisions in this paragraph for clarity.

b. Product Withdrawal and Uniform Modification of Coverage Exceptions to Guaranteed Renewability Requirements

The PHS Act provisions enacted by HIPAA and the Affordable Care Act require health insurance issuers to guarantee the renewal of coverage unless at least one of several listed exceptions applies.[16] One exception to the guaranteed renewability requirements permits an issuer to cease offering a particular product in a market and to discontinuing existing blocks of business with respect to that product (product withdrawal). This may be done, in accordance with State law, provided certain other requirements are met. The PHS Act also provides for issuers, only at the time of coverage renewal, to modify the health insurance coverage for a product offered to a group health plan or an individual in the individual market, if the modification is consistent with State law and effective uniformly for all group health plans or individuals with that product (uniform modification of coverage). The law contemplates that a uniform modification does not alter a policyholder's right to renewability, and that such modifications do not in effect result in the termination of the existing policy under the product withdrawal rules.

In this proposed rule, we propose standards defining whether certain modifications to a policy would constitute ''uniform modifications'' within the meaning of the PHS Act, or would constitute the withdrawal of the existing product and the creation of a new product. These provisions would be codified in each of the guaranteed renewability regulations at 45 CFR 146.152, 147.106, and 148.122, and would therefore apply to both grandfathered and non-grandfathered coverage in the group and individual markets.[17]

Definition of Uniform Modification of Coverage

We propose that a modification made solely pursuant to applicable Federal or State law would be considered a modification of coverage rather than a product withdrawal. These modifications could include changes required to comply with Affordable Care Act standards (such as elimination of a prohibited annual limit) and changes permitted based on updated standards (such as increasing an annual limitation on cost sharing based on the annual increase in the limit permitted as a result of the application of the premium adjustment percentage). Additionally, we propose that if an issuer makes changes to the health insurance coverage for a product that are not pursuant to applicable Federal or State law, the modifications would constitute a uniform modification of coverage for purposes of the guaranteed renewability requirements under the PHS Act if the product that has been modified meets all of the following criteria:

- The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act);
- The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO));
- The product covers a majority of the same counties in its service area;

[14] Although the Affordable Care Act creates a limited exception to the guaranteed availability requirements for qualified individuals purchasing coverage through an Exchange, if an individual declines or is ineligible to enroll through an Exchange and seeks enrollment directly with the issuer, issuers of coverage subject to the guaranteed availability requirements of section 2702 of the PHS Act must accept every individual in the State that applies for such coverage unless an exception applies.

[15] *See Fourco Glass Co.* v. *Transmirra Products Corp.,* 353 U.S. 222, 228 (1957) (citations omitted) (providing that, ''However inclusive may be the general language of a statute, it will not be held to apply to a matter specifically dealt with in another part of the same enactment.'' The same principle is used to resolve conflict between two statutes. *See* also, e.g., *United States* v. *Estate of Romani,* 523 U.S. 517, 532 (1998) (later, more specific statute governs). *See* also *Morton* v. *Mancari*, 417 U.S. 535, 550–51 (1974) (a general statute will not be held to have repealed by implication a more specific one unless there is ''clear intention otherwise'').

[16] *See* PHS Act sections 2703 (applicable to non-grandfathered health plans in the group and individual markets), section 2712 as codified prior to enactment of the Affordable Care Act (applicable to grandfathered health plans in the group market), and section 2742 (applicable to both grandfathered and non-grandfathered health plans in the individual market), as implemented in 45 CFR 146.152, 147.106, and 148.122.

[17] While the Affordable Care Act amended section 2703 of the PHS Act to generally apply to health insurance issuers in the group and individual markets, the uniform modification of coverage exception in section 2703(d) of the PHS Act addresses only the large and small group markets. Section 2742 of the PHS Act and the regulations at § 148.122(g) contain parallel provisions allowing for the uniform modification of coverage in the individual market. For ease of reference and to facilitate compliance, we propose to add a provision in § 147.106(e)(1) reiterating the uniform modification of coverage exception for non-grandfathered coverage in the individual market.

• The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act (e.g., bronze, silver, gold, platinum or catastrophic); and

• The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

Under this proposal, if an issuer modifies the coverage for a product and the resulting product is consistent with the above criteria, the issuer would be considered under the PHS Act to have made a uniform modification of coverage and therefore not to have withdrawn the product from that market. Conversely, if an issuer modifies the coverage for a product in a manner that results in a product that differs from the above criteria, the issuer would be considered to have changed the coverage to such extent that the issuer has withdrawn the existing product and created a new product.[18]

These criteria, if finalized, would establish minimum Federal standards determining whether coverage modifications constitute the continuance of an existing product in a market within a State for products offered both through and outside of an Exchange. We believe these proposed standards will minimize unnecessary terminations of coverage, ensuring predictability and continuity for consumers, while reasonably providing issuers the flexibility to make necessary adjustments to coverage.

We recognize that some States may have different definitions of what changes to a health insurance product constitute modifications and what changes constitute withdrawals and re-filings of new products. The definitions proposed here would preempt any conflicting State definitions. We acknowledge that the guaranteed renewability sections of the PHS Act provide that a uniform modification of coverage must, among other things, be ''consistent with State law.'' We interpret this statutory language as governing the extent or type of modifications that may legally be made under State law. As discussed in the preamble to the final rule published on February 27, 2013 under section 2703 of the PHS Act (78 FR 13419), State laws that prevent issuers from uniformly modifying coverage to comply with Federal law requirements would, in effect, prevent the application of such requirements and therefore be preempted.[19] Accordingly, under the approach we are proposing, States would have the flexibility to apply additional criteria that broaden the scope of what would be considered a uniform modification, but not narrow its scope.

We request comment on all aspects of this proposal.

Standard Consumer Notices When Discontinuing or Renewing a Product in the Group or Individual Market

To reduce confusion and ensure consumers receive clear, accurate, and consistent information about their coverage options, we are also proposing standard notice requirements when issuers discontinue or renew coverage in the group and individual markets.

First, under the current regulations, issuers electing to discontinue offering a particular product in a market must provide to each plan sponsor or individual provided that product (and to all participants and beneficiaries covered under such coverage) at least 90 calendar days' notice of the discontinuation in writing. We propose that, to satisfy this requirement, the issuer must provide notice ''in a form and manner specified by the Secretary.''

Second, we propose to establish a new notice requirement when issuers provide the option to renew coverage, including a renewal of coverage with modifications. We propose the issuer in this situation must provide written notice of the renewal to each plan sponsor in the small or large group market and to each individual policyholder in the individual market (as applicable). We propose this notice must also be provided in a form and manner specified by the Secretary.

We request comment on these proposals. Concurrently with the issuance of this proposed rule, we are publishing four draft notices in guidance that would be required to be used when issuers elect to discontinue or renew a product, consistent with the above discussion.[20] We solicit comments on the draft notices as described in the guidance.

Rate Review

Section 2794 of the PHS Act, and regulations at 45 CFR Part 154, establish a process whereby CMS or the applicable State will review rate increases of health insurance coverage that meet or exceed specified thresholds to determine if the rate increases are unreasonable. It has come to our attention, however, that some issuers may attempt to avoid review of rate increases by withdrawing a product(s) offered in the individual or small group market in a State and re-filing the product(s) as a ''new'' product(s) the following year. Under § 154.102, a ''rate increase'' is defined as ''any increase of the rates for a specific product offered in the individual or small group market,'' and a ''product'' is defined as ''a package of health insurance coverage benefits with a discrete set of rating and pricing methodologies that a health insurance issuer offers in a State.''

CMS intends to apply the criteria outlined above regarding product discontinuation and renewal to determine whether the rate filing is subject to review under 45 CFR Part 154. Specifically, if an issuer withdraws a product in a market in a State and, within a 12-month period, reintroduces a product in that market with modifications of the discontinued product that do not differ from the above criteria, we would consider the issuer to be continuing to offer the same ''product'' within the meaning of that term under § 154.102. As such, the rate filing for the product would be subject to the annual review of rate increases of health insurance coverage should it meet or exceed the specified thresholds to determine if the rate increase is unreasonable. CMS will consider compliance with the proposed criteria to constitute compliance with PHS Act section 2794 until this rulemaking is finalized.

We request comment on whether this clarification, or a cross-reference to the proposed definition of a uniform modification of coverage in § 147.106 of this proposed rule, should be added to Part 154.

C. Part 148—Requirements for the Individual Health Insurance Market

1. Conforming Changes to Individual Market Regulations (§§ 148.101 through 148.128)

The Health Insurance Portability and Accountability Act of 1996 (HIPAA),

[18] Whether an issuer is considered to offer the same product for purposes of this proposal is unrelated to and would not determine whether a plan maintains status as a grandfathered health plan under section 1251 of the Affordable Care Act and its implementing regulations. 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140.

[19] Patient Protection and Affordable Care Act; Health Insurance Market Rules; Rate Review, 78 FR 13406 (February 27, 2013).

[20] Standard Notices When Discontinuing or Renewing a Particular Product in the Group or Individual Market (March 14, 2014). Available at: *http://www.cms.gov/CCIIO/Resources/Files/Downloads/draft-notice-renewal-discontinuation-bulletin-3-14-2014.pdf.*

Public Law 104–191, was enacted in 1996 to provide for, among other things, improved portability and continuity of coverage in both the group and individual health insurance markets. Section 111 of HIPAA added sections 2741 through 2744 of the PHS Act to improve availability and renewability in the individual market. HIPAA also added provisions of the Code, the Employee Retirement Income Security Act of 1974 (ERISA), and the PHS Act governing the group health insurance market and group health plan coverage provided in connection with employment. These provisions permitted limited exclusions of coverage under certain circumstances based on preexisting conditions.

The individual health insurance market provisions of HIPAA are implemented in 45 CFR Part 148. These provisions guarantee the availability of individual health insurance coverage without preexisting condition exclusions for certain eligible individuals who lose group health insurance coverage; require issuance of certificates of creditable coverage; guarantee the renewability of individual health insurance coverage for all individuals; and set forth procedures for States that choose to implement an alternative mechanism under State law with respect to guaranteed availability for eligible individuals.

The Affordable Care Act added a new section 2704 of the PHS Act, which renumbered and amended the HIPAA requirements relating to preexisting condition exclusions.[21] In general, the new PHS Act section 2704 provides that a group health plan and a health insurance issuer offering group or individual health insurance coverage may not impose any preexisting condition exclusions. Section 2704 and the regulations under that section are generally effective for plan years (in the individual market, policy years) beginning on or after January 1, 2014, but for enrollees under the age of 19, the prohibition became effective for plan years (in the individual market, policy years) beginning on or after September 23, 2010.[22]

This proposed rule would make conforming amendments to the individual market provisions contained in Part 148 by removing provisions concerning preexisting condition exclusions that are superseded by new section 2704 of the PHS Act. These amendments would generally become applicable upon the effective date of the final rule. However, the proposed amendment to eliminate the requirement to issue certificates of creditable coverage is proposed to apply December 31, 2014, so that individuals needing to offset a preexisting condition exclusion under a group health plan that will become subject to the prohibition on preexisting condition exclusions starting with a plan year beginning on December 31, 2014, would still have access to the certificate for proof of coverage until that time. These proposed amendments are consistent with rulemaking amending the group market regulations under HIPAA[23] and with previously released guidance addressing the maintenance of State alternative mechanisms.[24]

We solicit comment on this proposal.

2. Fixed Indemnity Insurance in the Individual Health Insurance Market (§ 148.220)

Pursuant to PHS Act sections 2722(c)(2), 2763(b) and 2791(c)(3)(B), insurance that pays a fixed amount under specified conditions without regard to other insurance (''fixed indemnity insurance'') is considered to be an excepted benefit, exempt from many of the provisions of title XXVII of the PHS Act for the group and individual markets, if it meets all of the following conditions: (1) The benefits are be provided under a separate policy, certificate or contract of insurance; (2) there is no coordination between the provision of such benefits and any exclusion of benefits under any group health plan maintained by the same plan sponsor; and (3) such benefits are paid with respect to an event without regard to whether benefits are provided with respect to such event under any group health plan maintained by the same plan sponsor.

These statutory requirements are reflected in regulations at 45 CFR 146.145(b)(4) and 148.220(b)(3). In addition, under § 146.145(b)(4), incorporated through § 148.220(b)(3), benefits of fixed indemnity insurance in the group and individual markets must be paid on a fixed amount basis without regard to the cost of the item or service and can only be paid on a per-period basis as opposed to on a per-service basis in order to be treated as an excepted benefit.

The primary reason fixed indemnity insurance is considered to be an excepted benefit if it meets the statutory and regulatory criteria is that its primary purpose is not to provide major medical coverage but to provide a cash-replacement benefit for those individuals with other health coverage. Since the issuance of the regulations, however, various situations have come to the attention of HHS, the Department of Labor, and the Department of the Treasury (the Departments) where a health insurance policy is advertised as fixed indemnity coverage but pays a fixed amount based not on a period of time, but if a particular service is received. For example, the fixed indemnity coverage pays a fixed $50 per visit for doctors' visits, or $100 for a day of hospitalization, different fixed dollar amounts for other various surgical procedures, and/or a fixed $15 per prescription without regard to cost. In all cases, these fixed amounts are paid under these policies without regard to costs, and without regard to other insurance payments that may cover the same services. In such circumstances, the fixed payments for doctors' visits, surgery, and prescription drugs are not made not on a per-period basis, but instead based on the type of procedure or item, such as the surgery or doctor visit actually performed or the drug prescribed, and the amount of payment varies widely based on the type of surgery or the cost of the drug. Because these payments are not based on a ''fixed dollar amount per day (or per other period),'' such a policy is not an excepted benefit under the current regulations.

The Departments issued a frequently asked question (FAQ) on January 24, 2013 affirming that under the current regulations, for fixed indemnity insurance to be an excepted benefit, payment based on an event must be paid on a per-period basis as opposed to on a per-service basis.[25] While the FAQ only addressed fixed indemnity insurance sold in the group health

[21] The Affordable Care Act adds section 715(a)(1) of ERISA and section 9815(a)(1) of the Code to incorporate the provisions of part A of title XXVII of the PHS Act, including section 2704 of the PHS Act, into ERISA and the Code, and to make them applicable to group health plans and health insurance issuers providing health insurance coverage in connection with group health plans.

[22] PHS Act section 2704 applies to grandfathered and non-grandfathered group health plans and group health insurance coverage, and non-grandfathered individual health insurance coverage. It does not apply to grandfathered individual health insurance coverage. For more information on grandfathered health plans, *see* section 1251 of the Affordable Care Act and its implementing regulations at 26 CFR 54.9815–1251T, 29 CFR 2590.715–1251, and 45 CFR 147.140.

[23] *See* Ninety-Day Waiting Period Limitation and Technical Amendments to Certain Health Coverage Requirements Under the Affordable Care Act, 78 FR 10296 (February 24, 2014).

[24] *See* Questions and Answers Related to Health Insurance Market Rules, Q2. Available at: *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/qa_hmr.html.*

[25] *See* FAQs about Affordable Care Act Implementation (Part XI), Q7, available at *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs11.html* and *http://www.dol.gov/ebsa/faqs/faq-aca11.html.*

insurance market, the same analysis also applies to fixed indemnity insurance sold in the individual health insurance market, as noted above.

Since the issuance of the January 24, 2013 FAQ, however, stakeholders have expressed concerns over the distinction made under the current regulations between payment on a per-period basis (which is permitted) and payment on a per-service basis (which is not permitted). State insurance regulators indicated that they have for years been approving policies as fixed indemnity insurance that pay on a per-service basis and treating such coverage as an excepted benefit. In an August 27, 2013 letter to the Secretaries of the Departments on behalf of the National Association of Insurance Commissioners (NAIC), it was stated that ''state regulators believe hospital and other fixed indemnity coverage with variable fixed amounts based on service types could provide important options for consumers as supplemental coverage. Consumers who purchase major medical coverage that meets the definition of 'minimum essential coverage' may still want to buy fixed indemnity coverage to help meet out-of-pocket medical and other costs.'' Industry groups representing health insurance issuers have also expressed similar concerns.

Based on the feedback from stakeholders and the fact that, starting in 2014, most individuals are required to have minimum essential coverage in order to satisfy the individual shared responsibility requirement under section 5000A of the Code, CMS agrees that it is appropriate to revise the current regulatory criteria for individual market fixed indemnity coverage to be treated as an excepted benefit by (1) eliminating the current requirement that payment be made on a per-period basis and not on a per-service basis, and (2) among other things, imposing a new requirement that fixed indemnity insurance be sold only as secondary to other health coverage that meets the definition of minimum essential coverage.[26]

On January 9, 2014, the Departments published an FAQ stating that, ''HHS intends to propose amendments to 45 CFR 148.220(b)(3) that would allow fixed indemnity coverage sold in the individual health insurance market to be considered to be an excepted benefit if it meets the following conditions: (1) It is sold only to individuals who have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Code; (2) there is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage; (3) the benefits are paid in a fixed dollar amount regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to an event or service under any other health coverage; and (4) a notice is displayed prominently in the plan materials informing policyholders that the coverage does not meet the definition of minimum essential coverage and will not satisfy the individual responsibility requirements of section 5000A of the Code.'' [27] The FAQ further provided that, ''Until HHS finalizes this rulemaking related to these proposed amendments, HHS will treat fixed indemnity coverage in the individual market as excepted benefits for enforcement purposes if it meets the conditions above in States where HHS has direct enforcement authority. For States with primary enforcement authority, HHS encourages those States to also treat this coverage as an excepted benefit and will not consider that a State is not substantially enforcing the individual market requirements merely because it does so.''

Consistent with the January 9, 2014 FAQ, we are proposing the following revised criteria for fixed indemnity insurance to be treated as an excepted benefit in the individual health insurance market: (1) The benefits are provided only to individuals who have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Code; (2) there is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage; (3) the benefits are paid in a fixed dollar amount per day of hospitalization or illness or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage; and (4) a notice is displayed prominently in the plan materials in at least 14 point type that has the following language: ''THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.''

CMS is aware of at least one State law that requires fixed indemnity insurance to be sold as secondary to major medical insurance in order to be treated as an excepted benefit. We welcome comments on this approach including the language in the required notice. We also solicit comments on whether the requirement for individuals to have other minimum essential coverage in order to be sold fixed indemnity insurance is sufficient protection, especially given the fact that a group health plan that provides minimum benefits can be minimum essential coverage. For example, we solicit comment on whether to require that fixed indemnity insurance must only be sold to individuals with other health coverage that meets the EHB requirements. To meet the standard that fixed indemnity insurance must be sold on a secondary basis, an issuer of fixed indemnity insurance would have to be reasonably assured that an individual has obtained other health coverage that is minimum essential coverage. We seek comments on the extent of verification issuers should require from applicants to be reasonably assured that they have minimum essential coverage, including whether an attestation included in the application is sufficient.

The current regulation requires fixed indemnity insurance to be sold under a separate policy, certificate or contract of insurance but does not require that it be provided by an issuer other than the issuer providing the major medical coverage to the enrollees of the fixed indemnity insurance. The Departments previously released guidance establishing a safe harbor under which supplemental health insurance coverage will be considered to be an excepted benefit.[28] In the guidance, one of the criteria for the safe harbor is that the supplemental coverage has to be issued by an entity that does not provide the primary coverage under the plan in

[26] Fixed indemnity plans paying fixed amounts per service that meet these requirements to be excepted benefits do not qualify as permitted insurance that can be provided in addition to a High Deductible Health plan to an eligible individual under section 223(c)(3) of the Code. The statutory language for permitted hospitalization insurance specifically refers to ''insurance paying a fixed amount per day (or other period) of hospitalization'' rather than ''hospital indemnity or other fixed indemnity insurance.''

[27] FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation, Q11 (January 9, 2014). Available at: *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html* and *http://www.dol.gov/ebsa/faqs/faq-aca18.html.*

[28] *See* CMS Insurance Standards Bulletin 08–01 (available at *http://www.cms.gov/CCIIO/Resources/Files/Downloads/hipaa_08_01_508.pdf*); the Department of Labor's Employee Benefits Security Administration's Field Assistance Bulletin No. 2007–04 (available at *http://www.dol.gov/ebsa/pdf/fab2007-4.pdf*); and Internal Revenue Service Notice 2008–23 (available at *http://www.irs.gov/irb/2008-07_IRB/ar09.html*).

order for the supplemental coverage to be an excepted benefit. This prevents an issuer from carving out certain benefits from its major medical coverage and packaging those benefits with the major medical coverage as a supplemental excepted benefit. We are considering adding the same protection for fixed indemnity insurance sold in the individual market and welcome comments on this approach.

This proposal only addresses fixed indemnity insurance sold in the individual market. For fixed indemnity insurance sold in the group health insurance market, see the FAQ published by the Departments on January 9, 2014.

We believe that most fixed indemnity products in the individual market today will largely satisfy these criteria and we welcome comment on how this proposal would affect existing market arrangements. If these proposals are finalized, they would apply for policy years beginning on or after January 1, 2015. We welcome comments on whether this would provide a sufficient transition period. We also solicit comments on whether the existing regulatory criteria for fixed indemnity insurance to be an excepted benefit (as interpreted in our January 24, 2013 FAQ) should instead remain in place on a permanent basis or at least on a temporary basis to ensure a sufficient transition that avoids market disruption.

D. Part 153—Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment under the Affordable Care Act

1. Provisions and Parameters for the Transitional Reinsurance Program (§ 153.405)

The Affordable Care Act directs that a transitional reinsurance program be established in each State to help stabilize premiums for coverage in the individual market from 2014 through 2016. In the 2014 Payment Notice and the 2015 Payment Notice, we expanded on the standards set forth in subparts C and E of the Premium Stabilization Rule, and established the reinsurance payment parameters and uniform reinsurance contribution rate for the 2014 and 2015 benefit years. In this proposed rule, we solicit feedback on a potential revision to the allocation of reinsurance contributions collected for all benefit years such that reinsurance contributions collected are allocated first to the reinsurance payment pool and administrative expenses and second to payments to the U.S. Treasury.

Section 1341(b)(3)(B)(iii) of the Affordable Care Act specifies the total contribution amounts to be collected from contributing entities for the reinsurance payment pool as $10 billion for 2014, $6 billion for 2015, and $4 billion for 2016. Sections 1341(b)(3)(B)(iv) and 1341(b)(4) of the Affordable Care Act direct the collection of funds for contribution to the U.S. Treasury in the amounts of $2 billion for 2014, $2 billion for 2015, and $1 billion for 2016. Section 1341(b)(3)(B)(ii) of the Affordable Care Act allows for the collection of additional amounts for administrative expenses. Taken together, these three components make up the total dollar amount to be collected from contributing entities for each of the three years of the reinsurance program under a national per capita contribution rate. For 2014, to collect $12.02 billion, HHS set a per capita contribution rate of $63; for 2015, to collect $8.025 billion, HHS set a per capita contribution rate of $44.

In the 2014 and 2015 Payment Notices, we provided that if total contributions collected for 2014 and 2015 exceed $12.02 billion and $8.025 billion, respectively, we would allocate $2 billion to the U.S. Treasury, $20.3 or $25.4 million, as applicable, to administrative expenses, and would allocate all remaining contributions for reinsurance payments, thus prioritizing excess contributions towards reinsurance contributions. Due to the uncertainty in our estimates of reinsurance contributions to be collected, and to help assure that the reinsurance payment pool is sufficient to provide the premium stabilization benefits intended by the statute, we propose to revise our allocation of reinsurance contributions collected and adopt a similar prioritization in the event that reinsurance collections fall short of our estimates. Specifically, if collections fall short of our estimates for a particular benefit year, we propose to alter the allocation so that the reinsurance contributions that are collected are allocated first to the reinsurance pool and administrative expenses, and are allocated to the U.S. Treasury once the targets for reinsurance payments and administrative expenses are met. For example, as Table 1 provides, in 2014, reinsurance contributions would go first to the reinsurance payment pool and administrative expenses, up to $10.02 billion, and any additional contributions collected would be allocated to the U.S. Treasury, up to the total $12.02 billion.

TABLE 1—PROPORTION OF REINSURANCE CONTRIBUTIONS COLLECTED UNDER THE UNIFORM REINSURANCE CONTRIBUTION RATE FOR THE 2014 BENEFIT YEAR FOR REINSURANCE PAYMENTS, PAYMENTS TO THE U.S. TREASURY, AND ADMINISTRATIVE EXPENSES

Proportion or amount for:	If total contribution collections under the 2014 uniform reinsurance contribution rate are less than or equal to $10.02 billion	If total contribution collections under the 2014 uniform reinsurance contribution rate are more than $10.02 billion, but less than or equal to $12.02 billion	If total contribution collections under the 2014 uniform reinsurance contribution rate are more than $12.02 billion
Reinsurance payments.	99.9 percent ($10 billion/$10.02 billion)	$10 billion	Total collections less $2.02 billion (U.S. Treasury and administrative expenses).
Payments to the U.S. Treasury.	0 percent	Total collections less $10.02 billion	$2 billion.
Administrative expenses.	0.1 percent ($20.3 million/$10.02 billion).	$20.3 million	$20.3 million.

Therefore, if we collect $11 billion instead of $12.02 billion for 2014, we propose to fully fund the reinsurance payment pool and administrative expenses, and to pay to the U.S. Treasury $0.98 billion.

Similarly, for 2015, reinsurance contributions would go first to the reinsurance payment pool and

administrative expenses, up to $6.025 billion, and any additional contributions collected would be allocated to the U.S. Treasury, up to the total $8.025 billion.

TABLE 2—PROPORTION OF REINSURANCE CONTRIBUTIONS COLLECTED UNDER THE UNIFORM REINSURANCE CONTRIBUTION RATE FOR THE 2015 BENEFIT YEAR FOR REINSURANCE PAYMENTS, PAYMENTS TO THE U.S. TREASURY, AND ADMINISTRATIVE EXPENSES

Proportion or amount for:	If total contribution collections under the 2015 uniform reinsurance contribution rate are less than or equal to $6.025 billion	If total contribution collections under the 2015 uniform reinsurance contribution rate are more than $6.025 billion, but less than or equal to $8.025 billion	If total contribution collections under the 2015 uniform reinsurance contribution rate are more than $8.025 billion
Reinsurance payments.	99.9 percent ($6 billion/$6.025 billion)	$6 billion	Total collections less $2.025 billion (U.S. Treasury and administrative expenses).
Payments to the U.S. Treasury.	0 percent	Total collections less $6.025 billion	$2 billion.
Administrative expenses.	0.1 percent ($25.4 million/$6.025 billion).	$25.4 million	$25.4 million.

Therefore, if we collect $7 billion instead of $8.025 billion in 2015, we propose to fully fund the reinsurance payment pool and administrative expenses, and to pay to the U.S. Treasury $0.975 billion.

We note that in the 2015 Payment Notice, we amended 45 CFR 153.405(c) to provide a bifurcated contribution collection schedule, under which contributing entities would submit reinsurance contributions via two payments. The first payment would cover the contribution amount allocated to reinsurance payments and administrative expenses; the second payment would cover the contribution amount allocated to payments to the U.S. Treasury for the applicable benefit year. In light of our proposed allocation policy, we note that contributions collected in the second collection would be allocated for reinsurance payments and administrative expenses if the first collection does not fully provide for the target reinsurance pool and administrative expenses. Therefore, for 2014, if the first collection resulted in a total collection of $9 billion, any contribution collected via the second collection up to $1.02 billion would be allocated for reinsurance payments and administrative expenses.

We seek comment on this allocation proposal, including on the legal authority to implement a prioritization of reinsurance contributions to reinsurance payments over payments to the U.S. Treasury. We also seek comment on the appropriate and permissible prioritization of reinsurance administrative expenses, and whether those expenses should have the same or different priority as reinsurance payments or payments to the U.S. Treasury. In addition, we seek comment on alternative allocation approaches to provide the premium stabilization benefits of the reinsurance program, as intended by the statute.

2. Provisions for the Temporary Risk Corridors Program (§ 153.500)

In the 2015 Payment Notice, we indicated that we would consider additional adjustments to the risk corridors program for benefit year 2015. We did so recognizing that issuers of QHPs may face additional administrative costs, risk pool effects, and uncertainty for that benefit year related to State extensions of renewals of plans that do not comply with 2014 market reforms, including the rating rules, the additional time it will take to fully assess the risk profile of 2014 enrollees given the six-month initial open enrollment period, protracted phase-outs of high-risk pools, and the scheduled decline in the reinsurance program payments. We also recognize that issuers of QHPs may face additional costs from other transitions to the 2014 market rules, including the infrastructure requirements around Exchanges, and the distributed data collection methodology for risk adjustment and reinsurance. We note that these uncertainties will continue through the summer of 2014, while issuers are in the process of setting their rates for the 2015 benefit year. Therefore, for the 2015 benefit year, we are considering further adjustments to the risk corridors formula that would help to mitigate these additional administrative costs and uncertainties around operations and the risk pool, and to stabilize the market as it continues to transition to full compliance with Affordable Care Act provisions.

We propose to implement an adjustment to the risk corridors formula set forth in subpart F of part 153 for each of the individual and small group markets by increasing the ceiling on allowable administrative costs (currently set at 20 percent, plus the adjustment percentage, of after-tax premiums). Such an adjustment could increase a QHP issuer's risk corridors ratio if administrative expenses are unexpectedly high or claims costs are unexpectedly low, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the administrative cost ceiling by 2 percentage points, from 20 percent to 22 percent. We also propose to increase the profit margin floor in the risk corridors formula (currently set at 3 percent, plus the adjustment percentage, of after-tax premiums). Such an adjustment could increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridors payments or decreasing risk corridors charges. We propose to raise the profit margin floor by 2 percentage points, from 3 percent to 5 percent.

We are proposing to implement this proposed increase to the administrative cost ceiling and profit floor in a manner similar to the risk corridors adjustment percentage set forth in the 2015 Payment Notice. In the 2015 Payment Notice, we provided for an adjustment that would increase the administrative cost ceiling and profit floor in the risk corridors formula for QHP issuers in transitional States, in order to account for the effects of the transitional policy. In this proposed rule, we are proposing to increase the administrative cost and profit floor for 2015 for QHP issuers in every State for the reasons described below.

We note that, because the risk corridors program applies only to certain plans defined to be qualified health plans at 45 CFR 153.500, the extent to which an issuer may receive

the full effect of this adjustment would depend upon the portion of an issuer's individual and small group enrollees in plans subject to risk corridors. We intend to implement this program in a budget neutral manner, and may make future adjustments to program parameters, upwards or downwards, as necessary to achieve this goal.

We are proposing that these adjustments apply on a national basis for the 2015 benefit year because we believe that these additional transitional costs and uncertainties will be faced by issuers in all States, not just States adopting the transitional policy. Because many of these costs and uncertainties are difficult to measure, we believe it would be difficult to estimate them on an issuer-by-issuer or State-by-State basis. Additionally, we believe that a national adjustment would be administratively simple for issuers.

For example, issuers will continue to face administrative expenses in seeking to measure the extent to which issuers will extend renewals of plans through the 2015 rate-setting period. They will continue to accrue additional expenses monitoring the risk profile of 2014 enrollees during this period, particularly with the protracted phase-outs of high-risk pools. And they will continue to face uncertainty and administrative costs in measuring likely payouts from the reinsurance program. These costs were not anticipated when we established the 20 percent ceiling on administrative expenses; and we believe that these uncertainties will be difficult to accommodate as part of 2015 rate setting.

Although the adjustments that we are considering would affect each issuer differently, depending on its particular experience and administrative cost rate, we believe that, on average, the adjustment could suitably offset some of these increased costs.

We also propose that the medical loss ratio formula not take into account any additional risk corridors payments resulting from this adjustment, under our authority under section 2718(c) of the PHS Act to ''take into account the special circumstances of smaller plans, different types of plans, and newer plans.'' This proposed approach is similar to the policy established forth in the 2015 Payment Notice, which removes the effect of the risk corridors adjustment percentage from an issuer's MLR calculation.

We request comment on all aspects of this proposal. In particular, we request comment on the specific administrative costs associated with each of these policies, and other types of additional administrative or other expenses that will be incurred by issuers of QHP in 2015. We seek comment on the magnitude of these expenses, and whether these expenses could have been fairly estimated and included in premium rating. We seek comment on whether the administrative ceiling or the profit floor should be raised (or both), and in each case, by how much, to account for these costs and uncertainties. We also seek comment on alternate ways of implementing adjustments to the risk corridors program, including whether raising the administrative cost ceiling or raising the profit floor would alone be sufficient to help offset issuer's unexpected administrative expenses. Finally, we seek comment on whether certain limitations or conditions should be placed on the adjustment, and whether the adjustment should be limited to certain types of plans or should apply only in certain States.

E. Part 155—Exchange Establishment Standards and Other Related Standards Under the Affordable Care Act

1. Subpart B—General Standards Related to the Establishment of the Exchange

a. Non-Interference with Federal Law and Non-Discrimination Standards (§ 155.120)

In section 45 CFR 155.120(c), we established the requirement that the State and the Exchange, when carrying out the requirements of Part 155, must comply with any applicable non-discrimination statutes, and must not discriminate on the basis of race, color, national origin, disability, age, sex, gender identity or sexual orientation. We stated that the non-discrimination provisions of § 155.120(c) apply not just to the Exchanges themselves, but to Exchange contractors and all Exchange activities (including but not limited to marketing, outreach and enrollment), Navigators, non-Navigator assistance personnel, certified application counselors, and organizations designated to certify their staff and volunteers as certified application counselors (78 FR 42829). We also established in 45 CFR 155.105(f) that this non-discrimination requirement applies to the Federally-facilitated Exchanges.

We now propose to re-designate the introductory language in existing § 155.120(c) as a new section § 155.120(c)(1), re-designate existing § 155.120(c)(1) as a new § 155.120(c)(1)(i), and re-designate existing § 155.120(c)(2) as a new § 155.120(c)(1)(ii). We are proposing to make these technical changes to existing § 155.120(c) so that we can add a new paragraph (c)(2) to § 155.120 that creates a limited exception to the non-discrimination provisions in existing § 155.120(c)(1) and (c)(2). Under this proposed exception, an organization receiving Federal funds to provide services to a defined population under the terms of Federal legal authorities (for example, a Ryan White HIV/AIDS Program or an Indian health provider) that participates in the certified application counselor program under 45 CFR 155.225 may limit its provision of certified application counselor services to the same defined population without violating the non-discrimination provisions in existing § 155.120(c). We are proposing to adopt this exception to the non-discrimination provisions in order to allow such organizations to provide certified application counselor services and assist their defined populations in enrolling in health coverage offered through the Exchanges consistent with the Federal legal authorities under which such organizations operate.

To the extent that one of these organizations decides to take advantage of this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, we propose that the organization must refer the individual to other Exchange-approved resources, such as the toll-free Exchange call center, a Navigator, non-Navigator assistance personnel, or another designated certified application counselor organization, that are able to provide assistance to the individual.

However, to the extent that one of these organizations decides that it will not take advantage of this proposed exception, we propose that the non-discrimination provisions in existing § 155.120(c) would continue to apply. That is, if an organization decides that it will provide certified application counselor services to individuals that are not included in the defined population that it serves, it must provide those services to all individuals consistent with the non-discrimination provisions in existing § 155.120(c).

2. Subpart C—General Functions of an Exchange

a. Civil Money Penalties for Violations of Applicable Exchange Standards by Consumer Assistance Entities in Federally-Facilitated Exchanges (§ 155.206)

In a new § 155.206, as part of HHS's enforcement authority under section

1321(c)(2) of the Affordable Care Act, we propose to provide for the imposition of civil money penalties (CMPs) on Navigators, non-Navigator assistance personnel, and certified application counselors and certified application counselor designated organizations in FFEs and State Partnership Exchanges that do not comply with applicable Federal requirements. This proposal is designed to deter these entities and individuals from failing to comply with the Federal requirements that apply to them, and to ensure that consumers interacting with the Exchange receive high-quality assistance and robust consumer protection. As a general principle, while HHS proposes to establish authority to assess CMPs when appropriate, consistent with this proposed rule, we note that we also intend to continue to work collaboratively with consumer assistance entities and personnel to prevent noncompliance issues and address any that may arise before they might rise to the level where CMP would be assessed.

The Secretary, under the authority of sections 1311(i) and 1321(a)(1) of the Affordable Care Act, has previously established a range of consumer assistance programs to help consumers apply for and enroll in QHPs and insurance affordability programs through the Exchange. These consumer assistance programs include the Navigator program described at section 1311(i) of the Affordable Care Act and 45 CFR 155.210; the consumer assistance, outreach, and education functions authorized by section 1321(a)(1) of the Affordable Care Act and established at 45 CFR 155.205(d) and (e), which can include a non-Navigator assistance personnel program; and the certified application counselor program authorized by section 1321(a)(1) of the Affordable Care Act and set forth at 45 CFR 155.225. Under these authorities and the authority granted to the Secretary by section 1321(c)(1) of the Affordable Care Act, the FFE has implemented a Navigator and certified application counselor program in all States that did not elect to establish an Exchange, and has implemented a non-Navigator assistance program in some of those States, through an enrollment assistance contract.

Under section 1321(c)(2) of the Affordable Care Act, the provisions of section 2723(b) of the PHS Act [29] apply to the Secretary's enforcement, under section 1321(c)(1) of the Affordable Care Act, of the standards established by the Secretary under section 1321(a)(1) of the Affordable Care Act for meeting the requirements under title I of the Affordable Care Act, including the establishment and operation of Exchanges, without regard to any limitation on the application of the provisions of section 2723(b) of the PHS Act to group health plans. Section 2723(b) of the PHS Act provides the Secretary with authority to assess CMPs against health insurance issuers that fail to meet certain Federal requirements set forth in the PHS Act that apply to group health plans, in circumstances where, in the Secretary's determination, the State that regulates the issuer has failed to ''substantially enforce'' those requirements. We interpret the cross-reference to section 2723(b) of the PHS Act in section 1321(c)(2) of the Affordable Care Act as providing the Secretary with authority to assess CMPs to enforce requirements established under section 1321(a)(1) of the Affordable Care Act against any entity subject to those requirements, under circumstances where the Secretary is exercising her authority under 1321(c)(1) of the Affordable Care Act. For purposes of this proposal, we would consider that any State that has not elected to establish an Exchange, and in which the Secretary has therefore had to establish and operate an Exchange under section 1321(c)(1), is not ''substantially enforcing'' the requirements related to Exchanges that the Secretary has established under section 1321(a)(1).

Accordingly, HHS has the authority under section 1321(c)(2) of the Affordable Care Act to assess CMPs against Navigators, non-Navigator assistance personnel, and certified application counselors and certified application counselor designated organizations in FFEs, including State Partnership Exchanges, for violations of the requirements of the Navigator, non-Navigator, and certified application counselor programs that the Secretary established under section 1321(a)(1) of the Affordable Care Act. This proposal sets forth the circumstances under which the Secretary would exercise this authority. It is based on the enforcement scheme laid out in section 2723(b) of the PHS Act, and the implementing regulations at 45 CFR 150.301 *et seq.,* but it does not follow that enforcement scheme exactly, in light of the differences between the circumstances in which the Secretary would exercise her authority under PHS Act 2723(b) versus those under which she would exercise her authority under section 1321(c)(2) of the Affordable Care Act.

Proposed § 155.206(a) would establish the scope and purpose of the proposed CMP provisions and explains when and against whom HHS would assess a CMP under this proposal. At § 155.206(a)(2), we propose that HHS could permit an entity or individual to whom it has issued a notice of assessment of CMP to enter into a corrective action plan instead of paying the CMP. We specify that permitting an entity to enter into a corrective action plan would not limit HHS's authority to require payment of the assessed CMP if the corrective action plan is not followed. Under this proposal, the determination of whether HHS would enter into a corrective action plan in place of imposing a CMP would depend upon the factors proposed in § 155.206(h). We believe this approach would allow us not only to penalize violations if necessary, but also to prioritize working collaboratively with consumer assistance entities to ensure that improvements are made and future violations are prevented. We also believe this approach is consistent with the limitation on imposing CMPs that is set forth at PHS Act section 2723(b)(2)(C)(iii)(II), under which no CMP may be assessed for violations due to reasonable cause and not due to willful neglect, if the violation is corrected during the 30-day period beginning on the first day any of the entities against whom the penalty would be assessed knew, or exercising reasonable diligence would have known, that such failure existed.

We are considering whether to provide for an expedited process through which HHS may assess and impose CMPs, if extenuating circumstances exist or if necessary to protect the public. We believe HHS's ability to take swift action might be particularly useful in cases where HHS permits an entity to enter into a corrective action plan in lieu of a CMP, so that the entity would promptly begin remedial efforts under the corrective action plan without undue delay. We are considering an expedited process through which HHS would provide the consumer assistance entity less than the 30-day period provided for under proposed paragraph (e) to respond to the notice of investigation under proposed paragraph (e)(1), or possibly omit that period altogether. In all cases where an expedited process would apply, we anticipate that the entity against which a CMP is assessed would have an

[29] Section 1321(c)(2) of the Affordable Care Act erroneously cites to section 2736(b) of the PHS Act instead of 2723(b) of the PHS Act. This was clearly a typographical error, and we have therefore interpreted section 1321(c)(2) of the Affordable Care Act to incorporate section 2723(b) of the PHS Act.

opportunity to appeal the imposition of the penalty after it has been assessed. We seek comment on whether HHS should provide for such an expedited process and on all aspects of how it should be structured, including comments on how such an expedited process could provide sufficient protection to the public, comments on how such an expedited process could be sufficiently protective of the rights of entities and individuals that might be assessed a CMP, and comments on other ways through which the process for imposing CMPs under this proposal could be expedited if necessary to protect the public.

We are also considering implementing an approach that would give the HHS Office of Inspector General (OIG) concurrent authority with CMS to enforce violations under this section. Given OIG's expertise in investigating waste, fraud, and abuse in the Medicare and Medicaid programs, we are considering whether certain violations of an Exchange consumer assistance entity's program requirements might be most effectively investigated by OIG, or whether a more streamlined approach with a single enforcement authority would be preferable. In considering whether OIG should have concurrent enforcement authority under this proposed section, we are considering whether both CMS and OIG should use the procedures laid out in proposed § 155.206 for investigating potential violations and conducting administrative appeals, or whether and to what extent OIG should rely on its own enforcement procedures under 42 CFR, chapter V, subchapter B for either the investigative process or the administrative appeals process, or both, and whether some of the procedures outlined in OIG's enforcement procedures under those regulations should be incorporated into this section. We note that because our enforcement authority under section 1321(c)(2) of the Affordable Care Act requires compliance with the provisions of section 2723(b) of the PHS Act, any process used by OIG would have to comply with the requirements in those statutory provisions. We seek comment on whether OIG should have concurrent authority to enforce these proposed CMP provisions. In addition, we seek comment on what procedures we should use to determine which cases should fall under CMS or OIG enforcement authority, in the event OIG has concurrent authority. For example, we are considering providing that OIG would enforce only consumer assistance personnel or entity noncompliance involving systemic fraud or gross misconduct, rather than isolated incidents. We invite comment on this issue, and how those determinations would be made, as well as comments on any other aspects of a concurrent authority scheme that we should consider.

In proposed § 155.206(b), we specify the individuals and entities that could be subject to HHS' enforcement authority under this proposal. These individuals and entities would include Navigators, non-Navigator assistance personnel (also referred to as in-person assistance personnel) authorized under § 155.205(d) and (e), and certified application counselors and organizations designated as certified application counselor organizations in FFEs, including in State Partnership Exchanges. We refer to these individuals and entities in the proposed rule as ''consumer assistance entities,'' but these proposed CMPs could be assessed against both entities and individuals. We seek comment on whether all of the individuals and entities listed in proposed § 155.205(b) should be subject to CMPs, and on whether other entities and individuals should be added to that list.

In § 155.206(c), we propose the grounds on which HHS could impose CMPs on the entities and individuals specified in § 155.206(b). Section 1321(c)(2) of the Affordable Care Act authorizes the Secretary to enforce the requirements of section 1321(a)(1) of the Affordable Care Act, which include the requirements established by the Secretary regarding Exchange consumer assistance functions. Under our proposal, this statutory provision would authorize HHS to assess a CMP or, in lieu of a CMP, a corrective action plan against Navigators, non-Navigator assistance personnel, certified application counselors, and certified application counselor organizations in FFEs if HHS determines that these individuals or entities are not in compliance with the Exchange standards applicable to them. These Exchange standards would include any applicable regulations implemented under title I of the Affordable Care Act, as interpreted through applicable HHS guidance, such as the regulations governing consumer assistance tools and programs of an Exchange at § 155.205; those governing Navigators at § 155.210 and Navigators in FFEs at § 155.215; those governing certified application counselors at § 155.225; and those under § 155.215 governing non-Navigator assistance personnel in FFEs. These standards would also include any applicable HHS guidance interpreting an existing regulatory or statutory provision.

For example, § 155.215(b)(1)(i) requires FFE Navigators to obtain certification by the Exchange prior to carrying out any consumer assistance functions under § 155.210. Under this proposal, a Navigator who facilitates the selection of a QHP (a Navigator duty under § 155.210(e)(3)) prior to obtaining his or her Exchange certification might, depending on the circumstances, be subject to CMPs under § 155.206.

As another example, § 155.210(e)(2) requires Navigators to provide information and services in a fair, accurate, and impartial manner, and § 155.215(a)(2)(i) extends this duty to non-Navigator assistance personnel in FFEs. Any FFE Navigator or FFE non-Navigator assistance personnel who, while carrying out Exchange-related activities, furnishes information that he or she knew or should have known is false or fraudulent to consumers, the Exchange, or to HHS, would have violated these provisions and might, depending upon the circumstances, be subject to CMPs under proposed § 155.206. If a Navigator or any non-Navigator assistance personnel in a FFE encourages an applicant or enrollee to submit false information on an application for coverage though the Exchange, we would also consider that to be a violation of his or her duty to provide information in a fair, accurate, and impartial manner; and this violation might, depending on the circumstances, also subject the individual or entity to the proposed CMPs. Such a Navigator or non-Navigator assistance personnel would not be providing fair or accurate information to consumers, because in light of the penalties at section 1411(h) of the Affordable Care Act for providing false information on an Exchange application, it is not fair or accurate to state or imply that a consumer would be permitted to falsify application information.

As a final example, a certified application counselor in an FFE who steers consumers toward one particular QHP would not be acting in the best interest of consumers, as required by § 155.225(d)(4), and would not be giving consumers information about the full range of QHP options and insurance affordability programs for which they are eligible, as required by § 155.225(c)(1). Such a certified application counselor might, depending on the circumstances, be subject to CMPs under our proposed § 155.206.

We note that § 155.285 of this proposed rule would extend CMPs to consumer assistance entities who misuse or impermissibly disclose

personally identifiable information in violation of section 1411 of the Affordable Care Act. Therefore, we have not addressed penalties for those actions here. Some conduct by consumer assistance entities may warrant CMPs under either § 155.285 or § 155.206, and in such cases we believe HHS has discretion to determine whether to impose a CMP under this regulation or under § 155.285 of this subpart. However, we specify in proposed § 155.206(c) that HHS would not assess a CMP under this section if a CMP has already been assessed for the same conduct under § 155.285. Additionally, CMPs are not the only enforcement remedy that would apply to the entities and individuals who would be subject to proposed § 155.206. For instance, HHS could take other enforcement actions against FFE Navigators, which are Federal grantees, under the regulations governing HHS grants. Furthermore, some of the actions described above may subject consumer assistance entities to criminal liability under Federal or State law.

In § 155.206(d), we propose the basis for initiating an investigation of a potential violation. We propose that HHS could initiate an investigation based on any information it receives indicating that a consumer assistance entity might be in noncompliance with applicable Exchange standards. Such information could include consumer complaints, reports from State insurance departments and other Federal and State agencies, and any other information indicating such a violation. We also propose that any entity or individual could file such a complaint with HHS.

In § 155.206(e), (f) and (g), we propose to outline the process that HHS would follow to investigate potential violations in order to determine whether the consumer assistance entity has engaged in noncompliance of applicable Exchange standards. Under proposed § 155.206(e), if HHS learns of a potential violation through the means described in paragraph (d) in this section and determines that further investigation is warranted, HHS would provide written notice of its investigation to the consumer assistance entity. Such notice would describe the potential violation, provide 30 days from the date of the notice for the consumer assistance entity to respond and provide HHS with information and documents, including information and documents to refute an alleged violation, and would state that a CMP might be assessed if the consumer assistance entity fails to refute the allegations in HHS' determination.

In § 155.206(f), we propose a process for a consumer assistance entity to request an extension from HHS when the entity cannot prepare a response to HHS's notice of investigation within the 30 days provided in the notice. Under our proposal, if HHS grants the extension, the responsible entity would be required to respond to the notice of investigation within the time frame specified in HHS's letter granting the extension of time, and failure to respond within 30 days, or within the extended time frame, could result in HHS's imposition of the CMP that would apply based upon HHS's initial determination of a potential violation as set forth in the notice of investigation under § 155.206(e).

In § 155.206(g), we propose that HHS could review and consider documents or information received or collected in accordance with paragraph (d)(1) of this section or provided by the consumer assistance entity in response to receiving a notice in accordance with paragraph (e)(2) of this section. We also propose that HHS may conduct an independent investigation into the alleged violation, which may include site visits and interviews, if applicable, and may consider the results of this investigation in its determination. The purpose of these proposed provisions is to ensure that HHS would follow reasonable procedures when investigating a potential violation, and to allow a consumer assistance entity a reasonable timeframe to provide evidence refuting the allegation or other information regarding the alleged violation, including its severity or mitigating circumstances.

In § 155.206(h), we propose the factors that HHS would use to determine the appropriate CMP amount, and to determine whether it would be appropriate to offer the entity or individual an opportunity to enter into a corrective action plan in place of the CMP. We intend that the CMP amount, and opportunity to enter into a corrective action plan, would vary based on our assessment of the consumer assistance entity's previous or ongoing record of compliance; the gravity of the violation, as determined in part by the frequency of the violation and the financial harm incurred by a consumer; and the culpability of the consumer assistance entity, as determined, in part, by whether the entity received payment for committing the violation. We believe these factors would allow us to tailor enforcement actions to specific violations, while maintaining robust enforcement authority in the interest of protecting consumers.

Section 2723(b)(2)(C) of the PHS Act limits the amount of CMPs authorized under section 1321(c)(2) of the Affordable Care Act to $100 for each day for each individual directly affected. Therefore in § 155.206(i), we propose that the maximum daily amount of penalty assessed for each violation would be $100 for each day, for each consumer assistance entity, for each individual directly affected by the entity's non-compliance. Similar to our rules on the maximum penalty for noncompliant QHP issuers in 45 CFR 156.805(c), we anticipate that there might be situations where HHS cannot determine the number of individuals directly affected. Therefore, we propose, consistent with the approach under existing rules at 45 CFR 156.805(c), that in such situations HHS may reasonably estimate this number, based on available information, such as data from a Federal Navigator grantee's quarterly or weekly report concerning the number of consumers assisted. We also clarify that imposing $100 for each day an individual is directly affected would mean that we would look at the entirety of time the consumer was affected by the noncompliance of the assistance entity. For example, if a certified application counselor in an FFE is found to be steering consumers into a specific plan without regard to the consumers' best interests in violation of § 155.225(d)(4), we might assess CMPs based on our reasonable estimate of the number of consumers affected by the conduct, as well as the entire time the conduct took place, including the time during which each consumer is enrolled in the plan to which he or she was improperly steered. Although we have proposed a maximum per day penalty, we have not proposed a cap on the total penalty that could be assessed by HHS, and we seek comment on whether we should propose such a cap.

In proposed § 155.206(j), we propose to clarify that nothing in this section limits HHS's authority to settle any issue or case described in the notice furnished in accordance with paragraph (e), or to compromise on any CMP provided for in this section. This provision is based on a similar provision in the HIPAA enforcement scheme at 45 CFR 150.325.

Section 2723(b)(2)(C) of the PHS Act places certain limitations on CMPs authorized under section 1321(c)(2) of the Affordable Care Act, including the limitation that HHS will not assess a CMP where the entity did not know, or exercising reasonable diligence would not have known, of the violation. We propose to implement these limitations in § 155.206(k). We believe these limitations would help balance the interests of HHS, the Exchange, and consumers to have consumer assistance

entities exercise reasonable diligence in understanding and executing their obligations, while not unnecessarily penalizing consumer assistance entities who are acting in good faith. We also propose, based on the HIPAA enforcement structure at 45 CFR 150.341, that the burden is on the consumer assistance entity to establish that the circumstances triggering these limitations existed.

In § 155.206(l), we propose standards for notifying consumer assistance entities of the intent to assess a CMP, which notice would include an explanation of the entity's right to an appeal pursuant to the process set forth at 45 CFR Part 150, Subpart D, as provided in proposed § 155.206(m). We seek comment on whether all aspects of that process should be applicable to appeals of these CMPs. Finally, in § 155.205(n), we propose that HHS may require payment of the proposed CMP if the consumer assistance entity does not timely request a hearing.

We seek comment on all aspects of these proposals, including but not limited to whether other provisions of 45 CFR Part 150 should be adopted and made applicable to this proposed enforcement scheme, whether a specific limitations period should apply, and if so, what limitations period would be appropriate for violations of applicable Exchange standards by consumer assistance entities in FFEs.

b. Navigator, Non-Navigator Assistance Personnel, and Certified Application Counselor Program Standards (§§ 155.210, 155.215, and 155.225)

Sections 1311(d)(4)(K) and 1311(i) of the Affordable Care Act direct all Exchanges to establish a Navigator program. Section 1321(a)(1) of the Affordable Care Act directs the Secretary to issue regulations that set standards for meeting the requirements of title I of the Affordable Care Act, with respect to, among other things, the establishment and operation of Exchanges. Pursuant to the authority established in section 1321(a)(1), the Secretary issued 45 CFR 155.205(d) and (e), which authorize Exchanges to perform certain consumer service functions in addition to the Navigator program. 45 CFR 155.205(d) provides that each Exchange must conduct consumer assistance activities, and § 155.205(e) provides that each Exchange must conduct outreach and education activities to inform consumers about the Exchange and insurance affordability programs, to encourage participation.

The consumer assistance function authorized by § 155.205(d) includes the Navigator grant program established under section 1311(i) of the Affordable Care Act. Section 155.205(d) and (e) also allow for the establishment of a non-Navigator consumer assistance program. 45 CFR 155.215 establishes standards for non-Navigator assistance personnel in FFEs, including State Partnership Exchanges, and for non-Navigator assistance personnel in State Exchanges if they are funded with section 1311(a) Exchange Establishment grant funds. Also pursuant to the authority established in section 1321(a)(1), the Secretary issued 45 CFR 155.225, which establishes the certified application counselor program as a consumer assistance function of the Exchange, separate from and in addition to the functions described in §§ 155.205(d) and (e), 155.210, and 155.215.

Navigator duties and requirements for all Exchanges are set forth in section 1311(i) of the Affordable Care Act and 45 CFR 155.210. Additional duties and requirements for Navigators in Federally-facilitated and State Partnership Exchanges are set forth at 45 CFR 155.215. Section 155.215 also sets forth duties and requirements for non-Navigator assistance personnel in Federally-facilitated and State Partnership Exchanges, and for non-Navigator assistance personnel in State Exchanges if those personnel are funded with section 1311(a) Exchange Establishment grant funds. Certified application counselor duties and requirements for all Exchanges are set forth in 45 CFR 155.225.

In accordance with sections 1311(i)(4) and 1321(d) of the Affordable Care Act, we previously established in 45 CFR 155.210(c)(1)(iii) that Navigators ''must meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act.'' We have not established a similar requirement for the non-Navigator assistance personnel that are subject to 45 CFR 155.215. Nor did we finalize a proposed requirement that would have required certified application counselors to comply with State law as a condition of certification. However, we noted in the preamble to the rulemaking establishing the certified application counselor program that section 1321(d) of the Affordable Care Act provides that State laws that do not prevent the application of the provisions of title I of the Affordable Care Act are not preempted.[30] These preemption principles apply to all of the Federal standards and duties that apply to Navigators, non-Navigator assistance personnel and certified application counselors, since these have been authorized and established under title I of the Affordable Care Act.

We now propose to specify certain non-Federal requirements that would prevent the application of provisions of title I of the Affordable Care Act with respect to the Navigator, non-Navigator assistance personnel, and certified application counselor programs, within the meaning of section 1321(d) of the Affordable Care Act. This proposal does not purport to capture the complete universe of State requirements that might be preempted in this context, and we therefore recognize that a Federal court may also find other non-Federal requirements that we do not expressly mention in this proposed rule to be preempted.[31]

We propose amending § 155.210(c)(1)(iii) by adding new paragraphs (A) through (F) to specify certain non-Federal requirements that would prevent the application of the provisions of title I of the Affordable Care Act, within the meaning of section 1321(d) of the Affordable Care Act, with respect to the Navigator program. We also propose to amend § 155.215(f) to make clear that we would consider the same types of non-Federal requirements listed in § 155.210(c)(1)(iii)(A) through (F) (except for 155.210(c)(1)(iii)(D)) to prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act, when applied to non-Navigator assistance personnel subject to § 155.215. Similarly, with respect to the certified application counselor program, we propose amending § 155.225(d) by adding a new paragraph (d)(8) to specify that certified application counselors must meet any licensing, certification or

[30] Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel; Consumer Assistance Tools and Programs of an Exchange and Certified Application Counselors, 78 FR 42845 (finalized July 17, 2013).

[31] The U.S. District Court for the Western District of Missouri recently granted the plaintiff's motion for a preliminary injunction in litigation challenging a Missouri law regulating Navigators and other Exchange consumer assistance personnel on the grounds, *inter alia,* that certain provisions of the Missouri law are preempted by Federal law. The court concluded that ''state laws that make operation of the [Federally-facilitated Exchange] more difficult or onerous run afoul of the Affordable Care Act's purpose and are subject to preemption.'' *St. Louis Effort for AIDS, et al.* v. *Huff,* No. 13–4246–CV–C–ODS, 2014 WL 273201, at *5 (W.D. Mo. Jan. 23, 2014) (order granting preliminary injunction). This decision is currently under appeal before the United States Court of Appeals for the Eighth Circuit, *St. Louis Effort for AIDS* v. *Huff,* No. 14–1520 (8th Cir. appeal docketed Mar. 6, 2014).

other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. New § 155.225(d)(8) would also make clear that we would consider non-Federal requirements similar to those listed in § 155.210(c)(1)(iii)(A) through (F) (except for 155.210(c)(1)(iii)(D)) to prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act, when applied to certified application counselors.

As we discuss in greater detail below, these proposed amendments are directed at non-Federal requirements that conflict with Federal statutory or regulatory standards and that either, on their face, prevent assisters from performing their Federally required duties, or that would conflict with Federal standards in specific factual circumstances.

The purpose of these proposed provisions is to specify a non-exhaustive list of circumstances under which HHS would consider a non-Federal requirement applicable to Navigators, non-Navigator assistance personnel, or certified application counselors to prevent the application of provisions of title I of the Affordable Care Act, within the meaning of section 1321(d) of the Affordable Care Act. As a general principle, if a non-Federal requirement would, on its face, prevent Navigators, non-Navigator assistance personnel subject to § 155.215, or certified application counselors from carrying out Federally mandated duties or from otherwise meeting Federal standards that apply to them, or if a non-Federal requirement would make it impossible for an Exchange to implement those consumer assistance programs consistent with the Federal statutes and regulations governing those programs, then, in HHS's view, such a requirement would prevent the application of the provisions of title I of the Affordable Care Act.

These proposed preemption standards would not preclude a State from establishing or implementing additional State law protections for its consumers, so long as such laws do not prevent the application of Federal requirements for these consumer assistance programs. For example, a State may require these types of Exchange-approved assisters to undergo fingerprinting or background checks before they can operate in a State, so long as a State's implementation of these additional requirements does not prevent the Exchange from implementing these consumer assistance programs in the State consistent with Federal standards or make it impossible for the assisters to perform their Federally required duties.

We propose to make some, but not all, of the proposed provisions applicable to Navigators, non-Navigator assistance personnel subject to 45 CFR 155.215, and certified application counselors (or certified application counselor designated organizations) that are operating in State Exchanges. Non-Federal requirements that would prevent these individuals or entities from carrying out their Federally mandated duties or from otherwise meeting applicable Federal statutory and regulatory standards and requirements would prevent the application of title I of the Affordable Care Act. Generally, for the reasons addressed below, proposed § 155.210(c)(1)(iii)(A) through (D) would apply to Navigators in State Exchanges; through the cross reference to § 155.210(c)(1)(iii), proposed § 155.215(f) would apply provisions § 155.210(c)(1)(iii)(A) through (C) to non-Navigator assistance entities or individuals in State Exchanges that are funded through an Exchange Establishment Grant under section 1311(a) of the Affordable Care Act; and proposed § 155.225(d)(8)(i) through (iii) would apply to certified application counselors and/or designated certified application counselor organizations in State Exchanges. In general, we believe that the provisions listed above should apply in a State Exchange because these provisions address requirements that, in HHS' view, would facially conflict with Federal requirements or standards established under Federal law, while the provisions that we propose would not apply in State Exchanges relate to how the State interacts with an FFE or implements State requirements for the relevant consumer assistance personnel. Based on our observations, a State Exchange has an enhanced ability to work with the State to establish its own standards and coordinate the implementation of State law applicable to assisters in a manner that does not conflict with Federal standards or prevent the State Exchange from implementing consumer assistance programs consistent with Federal requirements. We solicit comments on whether all the proposed provisions should apply in State Exchanges. We also seek comments on whether there are other types of non-Federal requirements for these types of assisters in a State Exchange that might prevent the application of Federal law within the meaning of section 1321(d) of the Affordable Care Act.

In our proposal, we first propose that non-Federal laws or regulations which require Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors to refer consumers to agents or brokers, or to any other sources not required to provide them with impartial advice, would prevent the application of the provisions of title I of the Affordable Care Act. Non-Federal laws or regulations that require referrals to sources that are not required to provide impartial advice would, on their face, make it impossible for these assisters to comply with existing Federal statutory and regulatory duties and standards. Navigators are required to ''distribute fair and impartial information concerning enrollment in qualified health plans, and the availability of premium tax credits . . . and cost-sharing reductions . . .,'' under section 1311(i)(3)(B) of the Affordable Care Act. Additionally, section 1311(i)(5) of the Affordable Care Act requires the Secretary, in collaboration with States, to ''develop standards to ensure that information made available by [N]avigators is fair, accurate, and impartial.'' Accordingly, HHS regulations at § 155.210(e)(2) require Navigators in all Exchanges to provide ''information and services in a fair, accurate and impartial manner'' and HHS regulations at § 155.215(a)(1)(iii) require Navigators in Federally-facilitated and State Partnership Exchanges to ''provide information to consumers about the full range of QHP options and insurance affordability programs for which they are eligible.'' HHS regulations at § 155.215(a)(2)(i) and (iv) impose the same requirements upon non-Navigator assistance personnel in Federally-facilitated and State Partnership Exchanges. Similarly, § 155.225(c)(1) requires certified application counselors to provide ''information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible'' and § 155.225(d)(4) requires certified application counselors to act in the best interest of the applicants assisted. If a non-Federal law or regulation requires Navigators or non-Navigator assistance personnel subject to § 155.215 to refer consumers to third parties that do not have a duty to provide consumers with information that is fair, accurate, and impartial or requires a certified application counselor to refer consumers to third parties that do not

have a duty to act in the consumer's best interest, that non-Federal law would prevent Navigators, non-Navigator assistance personnel, or certified application counselors from meeting the above-mentioned Federal requirements. This proposal would apply in all Exchanges, with the following limited exception for certain Navigators. Where a State has elected to establish and operate only a SHOP Exchange pursuant to 45 CFR 155.100(a)(2), and has opted under 45 CFR 155.705(d) to permit Navigator duties at § 155.210(e)(3) and (4) in the SHOP-only State Exchange to be fulfilled through referrals to agents and brokers, we would not consider State laws or regulations that permit the State to take the option at § 155.705(d) to prevent the application of the provisions of title I of the Affordable Care Act, since that option is authorized under Federal law.

We solicit comment on whether non-Federal requirements that obligate Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors to refer employers and employees in the small group market to agents and brokers should not be considered to prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act.

Second, we propose that non-Federal laws or regulations that prevent Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors from providing services to all persons to whom they are required to provide assistance would also, on their face, prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. For example, if a non-Federal requirement prohibited Navigators and non-Navigator assistance personnel subject to § 155.215 from assisting an employer or employee regarding SHOP coverage or from acting as an intermediary between that employer and an issuer without being a licensed insurance agent or broker, then such a prohibition would prevent Navigators from performing their Federally required duties and would therefore prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. Specifically, such non-Federal requirements would prevent Navigators from providing ''information and services in a fair, accurate and impartial manner'' as required by 45 CFR 155.210(e)(2). They would also prevent non-Navigator assistance personnel subject to 155.215 from complying with the same requirement, as is required by § 155.215(a)(2)(i). We interpret the requirement that Navigators and non-Navigator assistance personnel subject to § 155.215 provide information and services fairly and impartially as a requirement that these assisters provide their services to all consumers seeking assistance. As we have mentioned in prior rulemaking, Navigators and non-Navigator assistance personnel should have the ability to help any individual who presents him or herself for assistance (see 78 FR 42830). Further, these requirements would prevent Navigators and non-Navigator assistance personnel subject to § 155.215 from being prepared to serve both the individual Exchange and SHOP, as required by § 155.215(b)(1)(v). Similarly, with respect to certified application counselors and certified application counselor organizations, if a non-Federal requirement barred these individuals or entities from assisting an employee with SHOP coverage, then such a requirement would prevent them from performing their Federally required duty to provide information to employees about the full range of QHP options for which they are eligible and assist employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs, as set forth under § 155.225(c)(1) and (2).

As another example, with respect to Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors and organizations, if a non-Federal law required these individuals or entities to either cease assisting a consumer or to discourage the consumer from seeking assistance from the assister whenever a consumer disclosed that he or she was currently insured or had previously purchased health insurance with the aid of an agent or broker (even if that consumer expresses to the assister that he or she does not want to be assisted by an agent or broker), then such a non-Federal requirement would prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. Specifically, these types of requirements would prevent Navigators from providing ''information and services in a fair, accurate and impartial manner'' as required by 45 CFR 155.210(e)(2). They would also prevent non-Navigator assistance personnel subject to 155.215 from complying with the same requirement, as is required by § 155.215(a)(2)(i). We interpret the requirement that Navigators and non-Navigator assistance personnel subject to § 155.215 provide information and services fairly and impartially as a requirement that these assisters serve any consumer who presents him or herself for assistance, without regard to whether the consumer has existing health insurance coverage or previously had such coverage. Such a non-Federal requirement would also keep these assisters from performing their Federally required duty to be prepared to serve both the individual Exchange and SHOP, as required by § 155.215(b)(1)(v). With respect to certified application counselors, these types of requirements would prevent them from carrying out required duties under § 155.225(c)(1) and (2), which require that certified application counselors provide information to employees about the full range of QHP options for which they are eligible and assist employees to apply for coverage in a QHP through the Exchange. Requirements of this type would also potentially prevent certified application counselors from acting in the best interests of the applicants assisted, as required by § 155.225(d)(4), especially in circumstances where a consumer expresses a desire to not consult an agent or broker.

Where a State has elected to establish and operate only a SHOP Exchange pursuant to 45 CFR 155.100(a)(2), and has opted under 45 CFR 155.705(d) to permit Navigator duties at § 155.210(e)(3) and (4) in the SHOP-only State Exchange to be fulfilled through referrals to agents and brokers, we would not consider State laws or regulations that permit the State to take the option at § 155.705(d) to prevent the application of the provisions of title I of the Affordable Care Act, since that option is authorized under Federal law.

Third, we propose that non-Federal laws that prevent Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors from discussing the terms of coverage of any particular policy or plan, or from providing advice regarding substantive benefits or comparative benefits of different health plans, would also, on their face, prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. Such non-Federal requirements would prevent Navigators from fulfilling their statutory and regulatory duties under section 1311(i)(3) of the Affordable Care Act and 45 CFR 155.210(e)(2) and (3) to distribute fair and impartial information concerning enrollment in qualified health plans and to facilitate enrollment

in qualified health plans. Such non-Federal requirements would also prevent non-Navigator assistance personnel subject to § 155.215 from carrying out their required duties under § 155.215(a)(2)(i), which requires that they comply with § 155.210(e)(2). Finally, such non-Federal requirements would also prevent certified application counselors and organizations from fulfilling regulatory duties established under § 155.225(c) to provide information to individuals and employees about the full range of QHP options and insurance affordability programs for which they are eligible, assist individuals and employees to apply for coverage in a QHP through the Exchange and for insurance affordability programs, and help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs. CMS interprets these statutory and regulatory provisions to require Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors to be prepared to discuss the terms and features of any coverage for which a consumer is or might be eligible, consistent with each consumer's expressed interests and needs, including, for example, plan features such as deductibles, coinsurance and copayments, coverage limitations or exclusions, and/or whether a particular provider or hospital is included within a plan's network. CMS has always interpreted the statute and regulations to prohibit Navigators, non-Navigators, and certified application counselors from steering a consumer toward a particular plan or plans. However, under 45 CFR 155.210(e)(3) and 155.215(a)(2)(i), Navigators and non-Navigator assistance personnel subject to § 155.215 have a duty to ''facilitate selection of a QHP,'' and that duty includes providing information to consumers about the substantive benefits or particular features of a health plan. Similarly, certified application counselors are required to provide this same type of information to consumers, since they have a duty under 45 CFR 155.225(c)(3) to help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs. We therefore propose that non-Federal requirements that prevent assisters from describing or providing information about the substantive benefits or particular features of a health plan, including comparative information to facilitate a consumer's selection of a plan, would prevent the application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act.

Fourth, we propose to put into regulatory text a position we previously expressed in preamble, that a State or an Exchange must not require that all Navigators be agents or brokers or carry errors and omissions coverage. Section 1311(i)(2)(B) of the Affordable Care Act provides that various types of entities may serve as Navigators, and through § 155.210(c)(2), we established the requirement that in all Exchanges, at least two types of entities, including one community and consumer-focused nonprofit group, must serve as Navigators. Requiring that each Navigator be a licensed agent or broker or carry errors and omissions coverage (which is typically held only by licensed professionals such as agents and brokers) would mean that all Navigators would fall under only one type of entity listed in 155.210(c)(2), specifically, agents and brokers, and would therefore prevent the application of § 155.210(c)(2)(i). In other words, these types of non-Federal requirements would make it impossible for the Exchange in such States to fulfill the Federal requirement that at least two types of entities listed at 155.210(c)(2), including one community and consumer-focused nonprofit group, serve as Navigators. HHS has previously advised (see 77 FR 18310, 18331–32) that such requirements would prevent the application of § 155.210(c)(2) within the meaning of section 1321(d) of the Affordable Care Act; this proposal makes this policy explicit in regulation text.

Fifth, we propose to specify that, in States with an FFE, non-Federal requirements may not, in effect, render ineligible any individuals or entities that the FFE would deem eligible under applicable Federal standards. Such non-Federal requirements would prevent the FFE from implementing the consumer assistance programs that they are required (or authorized) to implement under section 1311(i) of the Affordable Care Act, and 45 CFR 155.205, 155.210, 155.215, and 155.225, consistent with Federal requirements established for those programs.

For example, non-Federal requirements that prohibit Navigators, non-Navigator assistance personnel, or certified application counselors or organizations in an FFE from receiving any consideration, directly or indirectly, from a health insurance issuer offering health insurance coverage in or outside of an Exchange, even if not in connection with the enrollment of individuals into a QHP, go beyond Federal conflict of interest standards set forth in section 1311(i)(4)(A)(i) and (ii) of the Affordable Care Act and §§ 155.210(d)(4), 155.215(a) and 155.225(d)(2) and (4), as interpreted in Federal guidance, and would also go beyond the parallel conflict of interest standards proposed for certified application counselors in our proposed § 155.225(g)(2). For Navigators, section 1311(i)(4)(A)(i) and (ii) of the Affordable Care Act and 45 CFR 155.210(d)(4) together provide that a Navigator shall not be a health insurance or stop loss insurance issuer or receive any consideration directly or indirectly from a health insurance issuer or issuer of stop loss insurance in connection with the enrollment of any qualified individuals or employees of a qualified employer in a qualified health plan or a non-qualified health plan. Under 45 CFR 155.215(a)(2), a set of parallel conflict of interest standards apply in FFEs (including State Partnership Exchanges) to non-Navigator assistance personnel carrying out consumer assistance functions under 155.205(d) and (e), and to non-Navigator assistance personnel in a State Exchange funded through Federal Exchange Establishment grants.[32] For certified application counselors, conflict of interest standards in § 155.225(d)(2) require that each staff member or volunteer seeking certification disclose to the organization, or to the Exchange if directly certified by an Exchange, and to potential applicants, any relationships the certified application counselor or sponsoring agency has with QHPs or insurance affordability programs, or other potential conflicts of interest.[33]

A non-Federal requirement that prohibits consumer assistance entities and individuals from receiving any

[32] For Navigators and non-Navigator assistance personnel subject to 155.215, we have clarified in Federal guidance the scope of these conflict of interest standards. Specifically, conflict of interest standards do not apply to consideration received by a provider to support specific activities, such as the provision of medical services, if the consideration is not connected to the enrollment of individuals or employees in QHPs (78 FR 42831). In addition, Federal regulations do not inherently prohibit Navigators from receiving grants and other consideration from health insurance issuers for activities unrelated to enrollment into health plans (77 FR 18332); For example, entities such as chambers of commerce, that include as a constituent member an association that has members of or lobbies on behalf of the insurance industry, are not prohibited from serving as Navigator grantees (78 FR 42835).

[33] We have clarified in guidance that no conflict of interest should bar an otherwise eligible individual from serving as a certified application counselor, provided that they disclose any conflicts of interest, including but not limited to, any relationships with QHPs or insurance affordability programs, such as Medicaid plans and Medicaid managed care organizations (78 FR 42842).

consideration, directly or indirectly, from a health insurance issuer offering health insurance coverage in or outside of an Exchange, even if not in connection with the enrollment of individuals into a QHP, would prevent an FFE from approving as Navigators, non-Navigator assistance personnel, or certified application counselors and organizations certain entities, including hospitals and community health care clinics, that would otherwise be eligible to serve in those capacities. Further, with respect to the Navigator program, we further note that such a requirement could bar the FFE from awarding a grant to the most qualified applicants as required and therefore might prevent HHS from allocating Federal money in the most appropriate manner.

As another example, if a State with an FFE effectively prohibits an individual or organization from serving as a Navigator, non-Navigator assistance personnel or certified application counselor in the FFE merely because the individual or entity does not maintain its principal place of business in that State, that State could render ineligible individuals or entities that the FFE would deem eligible under applicable Federal standards. Such a standard would therefore prevent the FFE from implementing the consumer assistance programs that it is required (or authorized) to implement, within the meaning of section 1321(d) of the Affordable Care Act. We mean to address here only non-Federal requirements that would interpret ''principal place of business'' as meaning that a business could have only one principal place of business nationwide, in a single State (similar to the legal concept that may be used in determining corporate citizenship for purposes of establishing diversity jurisdiction in Federal court, as required under 28 U.S.C. 1332(c)). States may however, require organizations to register with or be incorporated in the State, which will allow States and Exchanges to work with these organizations to ensure that they are meeting the needs of their consumers.

Sixth and last, we propose to specify that in the FFEs, States may not impose requirements that, as applied or as implemented in the State, prevent the application of Federal standards applicable to Exchanges, Navigators, non-Navigator assistance personnel subject to § 155.215, and certified application counselors and designated organizations. For example, with respect to the Navigator program, if a State with an FFE implemented a requirement that prevented the only Navigator entity operating in the State from continuing to perform its Federally required duties, then such a provision, as applied, would prevent the Exchange from operating a Navigator program in that State as section 1311(i)(1) of the Affordable Care Act and § 155.210(a) require. As another example, a State might impose requirements as mandatory conditions for continuing to perform any applicable Federally required duties, such as additional training or fingerprinting or background checks, which, on their face, we consider as generally permissible, but might also set a deadline for compliance that made it impossible for any of individual or entity approved by the FFE to comply on a timely basis, despite good faith efforts to comply. Under such circumstances these entities and individuals could not fulfill any of their Federally required duties, and the FFE could not operate the consumer assistance programs that it is required (or authorized) to implement under section 1311(i) of the Affordable Care Act, and 45 CFR 155.205, 155.210, 155.215, and 155.225.

We believe these proposals will provide additional clarity regarding HHS's position with respect to whether a non-exhaustive list of specific non-Federal requirements would prevent the application of Federal requirements applicable to Navigators, non-Navigator assistance personnel, and certified application counselors and Exchanges' operation of such programs, within the meaning of section 1321(d) of the Affordable Care Act. In advancing these proposals, HHS's intent is to accord all States the comity that they are due under section 1321(d) of the Affordable Care Act, while preserving the ability of Exchanges, and the individuals and entities approved by Exchanges, to carry out such programs. HHS proposes these provisions to ensure that it can establish and operate the consumer assistance functions of an FFE consistent with the Federal requirements set forth in section 1311(i) of the Affordable Care Act and 45 CFR 155.205, 155.210, 155.215, and 155.225. We solicit comments on all aspects of these proposals.

This proposed rule would also amend some of the current regulatory prohibitions on Navigator conduct. If these proposals are finalized, we expect that they would be effective on the date the final regulations are effective.

Section 155.210(d), among other things, currently prohibits Navigators from being health insurance issuers or stop-loss issuers. We propose to amend section 155.210(d) by adding a provision that would provide that Navigators may not charge consumers for performing any Navigator duties. Our proposal would prohibit Navigators from requesting any form of remuneration from consumers for Navigator duties, such as charging fees, asking for favors in exchange for services provided, or requesting compensation from consumers for Navigator duties. As we previously explained in preamble when existing rules establishing a prohibition on charging fees by certified application counselors were finalized, HHS does not believe that it would be consistent with the purpose of the Navigator program or the consumer assistance, education, and outreach functions under § 155.205(d) and (e), for Navigators to charge consumers for their services. (78 FR 42829) The goal of the Navigator program is to provide consumers with information about and assistance with enrollment in coverage through the Exchange, without cost to the consumer. That is why the Affordable Care Act, at section 1311(i)(1), makes clear that Navigator duties must be funded by the Exchange through grants. We believe that having free assistance available to consumers helps further both the goals of the Navigator program and the Exchanges generally by supporting access for low-income individuals who might previously have been priced out of the health insurance market. We now propose to make this an express prohibition in our regulations, through the addition of a new provision at § 155.210(d)(5). If finalized, this prohibition would also apply to non-Navigator assistance personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) in an FFE and to non-Navigator assistance personnel funded through an Exchange Establishment Grant, since existing rules at § 155.215(a)(2)(i) require that these entities must comply with the prohibitions on Navigator conduct set forth at § 155.210(d). We think the same rationale for the prohibition generally applies in the case of non-Navigator personnel. This proposal would also align the Navigator and non-Navigator assistance personnel provisions with the similar provision applicable to certified application counselors in existing § 155.225(g).

Our proposal would not prevent Navigators from charging for other, non-Navigator-related services the organization may offer, given that section 1311(i)(2) of the Affordable Care Act and implementing regulations at § 155.210(c)(2) allow for various commercial entities or associations to become Navigators.[34] We do not intend

[34] Specifically, section 1311(i)(2)(B) and § 155.210(c)(2) provide that Navigator entities may

to prevent a Navigator entity or individual Navigators from pursuing the normal course of their non-Navigator-related business or established non-Navigator-related programs. However, Navigators would not be permitted to solicit customers for their other, non-Navigator-related services in connection with their Navigator duties. For example, a hospital conducting outreach and education events as a Navigator would not be permitted to use these events as opportunities to solicit new patients.

We also propose to amend § 155.210(d) to provide that Navigator organizations would be prohibited from compensating individual Navigators on a per-application, per-person assisted, or per-enrollment basis. We believe that such practices create adverse incentives that may result in enrollment errors or even improper conduct on the part of the Navigator, such as favoring consumers who take less time to assist than other consumers, or pressuring consumers to make quick decisions about their health coverage, rather than ensuring that they are fully informed about the full range of their options. Additionally, such a compensation methodology is inconsistent with the statutory and regulatory scheme for Navigators. We request comment on whether this proposal would negatively affect existing Navigator programs, including whether it would present implementation challenges for these programs if it becomes effective before November 15, 2014.

The duties of a Navigator under section 1311(i)(3) of the Affordable Care Act and § 155.210(e) are not limited to facilitating selection of a QHP. Navigators' duties also include conducting public education activities; distributing fair and impartial information about qualified health plans and advance payments of the premium tax credit and cost-sharing reductions; providing appropriate referrals for consumers with complaints, questions, or grievances about their health plan, coverage, or a determination under such plan or coverage; and providing information in a manner that is culturally and linguistically appropriate and accessible to people with disabilities. We believe that compensating Navigators based on the number of successful applications or enrollments may create disincentives to perform the full spectrum of required duties. To discourage improper conduct and ensure that Navigators fully perform each of their required duties, we propose to prohibit such compensation arrangements. Under the proposal, Navigators would be permitted to pay employees on a salaried basis, on a per-hour basis, or any other way that is not tied to the numbers of consumers who apply or enroll successfully with the Navigator's assistance. Because § 155.210 applies to all Navigators, including those in States with State Exchanges, this prohibition would apply to Navigators in all States. We seek comment on this proposal and alternatives that build in rewards for performance without the unintended consequences previously described.

As with Navigators, we believe it is important that non-Navigator assistance personnel authorized under § 155.205(d) and (e) in FFEs and in State Exchanges if funded through section 1311(a) Exchange Establishment grants focus on providing full and accurate information rather than on meeting quotas. Because § 155.215(a)(2) applies the prohibitions on certain conduct established for Navigators in § 155.210(d) to non-Navigator assistance personnel in FFEs, State Partnership Exchanges, and in State Exchanges if funded with section 1311(a) Exchange Establishment grants, these prohibitions on Navigator conduct would also apply to these non-Navigator assistance personnel, and would help decrease the risk of creating adverse incentives that could potentially lead to improper conduct.

In § 155.210(d)(7), we propose that Navigators be prohibited from providing gifts to applicants or potential enrollees as an inducement for application assistance or enrollment, including gift cards or cash, unless they are of nominal value. We propose to define nominal value as a cash value of $15 of less, or an item worth $15 or less, based on the retail purchase price of the item regardless of the actual cost. This definition would be consistent with the definition used for nominal value in connection with prohibitions applicable to the marketing of Medicare Advantage and Medicare Part D plans. (See 73 FR 54236) CMS proposes that it would update the definition of nominal value in guidance as necessary to account for inflation and other relevant factors. We seek comment on how nominal value should be defined in this context.

We also propose in § 155.210(d)(7) to prohibit Navigators from providing any applicant or potential enrollee with promotional items, that is, items that market or promote the products or services of a third party. There are several reasons we are proposing these prohibitions. First, providing cash or gifts, other than those of nominal value, would not be an appropriate use of Navigator grant funds, which are intended to be used to support a Navigator's outreach, education, and application assistance activities. In addition, section 1311(d)(5)(B) of the Affordable Care Act prohibits an Exchange from utilizing any funds intended for the administrative and operational expenses of the Exchange, which would include the funds used to pay for the Exchange's grants to Navigators, to pay for promotional giveaways. Second, the provision of cash or gifts to potential applicants or enrollees may shift the focus of a Navigator's interaction with a potential applicant or enrollee away from its duties to provide information and services in a fair, accurate, and impartial manner and to facilitate selection of a QHP, in appropriate circumstances. Offering cash or gifts to potential applicants or enrollees could also cause some consumers to approach Navigators for reasons other than the receipt of information and Exchange application assistance. Third, providing to applicants or potential enrollees any promotional items that market or promote the products or services of a third party would be in conflict with the Navigator's duty to be fair and impartial in its dealings with consumers, since it introduces a third party's interests and marketing goals into the relationship between a Navigator and the consumers they serve. We believe that the duty of a Navigator to provide information and services in a fair, accurate and impartial manner make it inappropriate for a Navigator to engage in activities that give the appearance of promoting or marketing the products or services of third party business interests when it is performing Navigator activities and services.

We are also proposing in § 155.210(d)(8) and (9) new standards for Navigators with respect to their contacts and interaction with consumers, and the outreach and marketing practices they use when offering their services. In § 155.210(d)(8), we propose to prohibit Navigators from going door-to-door or using other unsolicited means of direct contact to help consumers fill out applications or enroll in health coverage, although these proposed rules would not prohibit a Navigator from going door-to-door to provide consumers with educational or outreach materials. This would include making cold calls to a consumer to provide

include, among others, trade, industry, and professional associations; commercial fishing industry organizations; ranching and farming organizations; community and consumer-focused nonprofit groups; chambers of commerce; unions, resource partners of the Small Business Administration; and licensed agents and brokers.

application or enrollment assistance, without the consumer initiating the contact. In § 155.210(d)(9), we propose to prohibit Navigators from making robocalls, or calls that use an automatic telephone dialing system or an artificial or prerecorded voice, when initiating contact with consumers. We believe that these standards will ensure that Navigator practices are protective of the privacy and security interests of the consumers they serve, and will also provide important guidance and peace of mind to consumers, when they are faced with questions or concerns about what to expect in their interactions with individuals offering Exchange assistance. We seek comment about whether any of the activities and strategies that we propose to prohibit for Navigators are appropriate and consistent with section 1311(i) of the Affordable Care Act.

For the same reasons, the proposed standards established in § 155.210(d)(7), (8) and (9) would also apply to non-Navigator assistance personnel in FFEs, State Partnership Exchanges, and in State Exchanges if funded with section 1311(a) Exchange Establishment grants, through the reference in § 155.215(a)(2), which applies the prohibitions on conduct established for Navigators in § 155.210(d) to these types of non-Navigator assistance personnel.

In addition, we propose to amend paragraph (e), which describes the duties of a Navigator, by adding a new paragraph (e)(6) that would require Navigators to provide applicants and enrollees seeking their assistance with notice of the functions and responsibilities of Navigators, to obtain written authorization from those they are assisting, in a form determined by the Secretary, and to retain these authorization forms. We propose that Exchanges must establish a reasonable retention period for maintaining this authorization, and that in FFEs the retention period would be three years, unless a different retention period has already been provided in the administrative requirements for CMS grant and cooperative agreement recipients at 45 CFR 92.42 and 45 CFR 74.53 or in other applicable Federal law. We have considered specifying a retention period for all Exchanges, including specifying either a minimum retention period or a specified retention period ranging from three to five years, and solicit comments on the best approach. We also propose that consumers would be able to revoke this authorization at any time. These provisions would ensure that all consumers receive adequate notice of the role and duties of a Navigator and that all consumers give their informed consent before sharing any personally identifiable information with the Navigator.

For the same reasons, we also propose to add a new § 155.215(g) applying these authorization provisions to non-Navigator assistance personnel authorized under § 155.205(d) and (e) in FFEs, State Partnership Exchanges, and in State Exchanges if funded through section 1311(a) Exchange Establishment grants.

Finally, we propose to add a new § 155.210(e)(7), requiring Navigators to maintain a physical presence in their Exchange service area, so that face-to-face assistance can be provided to applicants and enrollees. Under this proposal, a Navigator would not be required to have its principal place of business in the State in which Navigator services are being provided. For the same reasons, we also propose to add a new § 155.215(g), to make the same provisions proposed for Navigators under § 155.205(e)(7), as outlined above, also applicable to non-Navigator assistance personnel subject to § 155.215.

We solicit comments on all aspects of these proposals.

c. Certified Application Counselors (§ 155.225)

Section 1321(a)(1) of the Affordable Care Act directs and authorizes the Secretary to issue regulations setting standards for meeting the requirements under title I of the Affordable Care Act, with respect to, among other things, the establishment and operation of Exchanges. Pursuant to this authority, the Secretary issued § 155.225, which establishes the certified application counselor program as a consumer assistance function of the Exchange separate from and in addition to the functions described in §§ 155.205(d) and (e), 155.210, and 155.215.

Section 155.225(b) establishes standards for the designation of a certified application counselor organization by an Exchange. We propose to add to these designation standards a new § 155.225(b)(iii) which would establish the requirement that certified application counselor organizations maintain a physical presence in the Exchange service area, so that face-to-face assistance would be provided to applicants and enrollees. This proposed requirement would also facilitate consumer protection efforts by a State. We note that, under this proposal, an entity designated as a certified application counselor organization would not be required to have its principal place of business in the State in which certified application counselor services are being provided by the organization.

Section 155.225(d) currently sets forth CAC certification standards, including the successful completion of Exchange-approved training. We propose to amend 45 CFR 155.225(d) to propose, in a new paragraph (d)(7), that individual certified application counselors would also be required to successfully complete Exchange-approved recertification training and be recertified on at least an annual basis. This proposal would ensure that certified application counselors keep up to date with current Exchange requirements and that they remain appropriately trained in order to best serve consumers. Under this proposal, each Exchange would establish its own recertification standards consistent with these requirements.

Existing § 155.225(f)(2) provides that certified application counselor organizations, or, if applicable, an Exchange that certifies staff members or volunteers of organizations directly, must establish procedures to ensure that consumers provide authorization before a certified application counselor has access to the consumer's personally identifiable information, and that the organization or application counselor must maintain a record of the authorization. We propose to revise this paragraph to clarify the retention period of the authorization form. We propose that Exchanges would be required to establish a reasonable retention period for maintaining this authorization, and specify that in FFEs, the retention period would be three years. We based this period on the retention period in the current administrative requirements for CMS grant and cooperative agreement recipients at 45 CFR 92.42 and 45 CFR 74.53. Because certified application counselors perform similar duties to Navigators and are subject to similar privacy and security requirements, we believe a similar retention period should apply, even though certified application counselors would not necessarily be HHS grantees. We have considered specifying a retention period for all Exchanges, including specifying either a minimum retention period or a specified retention period ranging from three to five years, and solicit comments on the best approach.

Under existing regulations at 45 CFR 155.225(g), certified application counselors ''may not impose any charge on applicants for application or other assistance related to the Exchange.'' This was intended as a strict prohibition on the imposition of charges or fees by

certified application counselors. We now propose to amend § 155.225(g) to substitute ''must not'' for ''may not,'' so that there can be no doubt about the intent of this requirement.

We also propose to amend 45 CFR 155.225(g) to reorganize and renumber this section and to propose several additional standards for certified application counselors. We propose that what is now § 155.225(g) should be renamed as a section establishing standards related to ''fees, consideration, solicitation and marketing.'' We propose to redesignate amended § 155.225(g) as § 155.225(g)(1) and add the new prohibitions in this amended section to new §§ 155.225(g)(2) through (6).

In § 155.225(g)(2), we propose to expressly prohibit certified application counselors from receiving consideration, directly or indirectly, from health insurance issuers or stop loss issuers in connection with the enrollment of consumers in qualified health plans (QHPs) or non-QHPs. This proposed new requirement would align with the same standards of conduct applicable to Navigators and certain non-Navigator assistance personnel under 45 CFR 155.210(d)(4) and 155.215(a)(2)(ii), and would apply to individual certified application counselors as well as to the organizations that have been designated as certified application counselor organizations. The reason for this proposal is that, in our view, receiving commissions or other consideration for enrollment in QHPs or non-QHPs is not consistent with the purpose and scope of certified application counselor program activities. Under § 155.225(c), certified application counselors must act in the best interest of consumers they assist, inform consumers about the full range of health coverage options and affordability programs for which they are eligible, and help to facilitate enrollment of eligible individuals in QHPs and insurance affordability programs. As such, neither an individual certified application counselor nor his or her designated organization should have any personal financial incentive to recommend a particular health coverage option.

Under this proposed amendment, while an Exchange could certify individuals as certified application counselors who are agents or brokers, and a designated certified application counselor organization similarly could certify staff or volunteers as certified application counselors who are agents or brokers, those individuals and the certified application counselor organization itself would not be permitted to receive compensation from health insurance or stop loss insurance issuers for enrolling individuals in QHPs or non-QHPs. Under this proposed amendment, in other words, certified application counselors and the certified application counselor designated organizations with which they are affiliated would not be strictly prohibited from being agents and brokers, as long as they do not receive any consideration in connection with enrollment of a consumer in a QHP or non-QHP. Therefore, agents and brokers who sell lines of insurance other than health insurance or stop loss insurance (for example, auto, life, and homeowners' policies) would not be prohibited from receiving consideration from the sale of those other lines of insurance while serving as a certified application counselor, provided they disclose the relationship to the consumer receiving assistance. We note that § 155.225(d)(2) requires a certified application counselor to disclose any relationship he or she or the sponsoring certified application counselor agency has with QHPs or insurance affordability programs, ''or other potential conflicts of interest,'' to the appropriate parties outlined in that provision. Consistent with the interpretation we advanced with respect to the Navigator program, we interpret ''other potential conflicts of interest'' in this context to include any private or personal interest sufficient to influence, or appear to influence, the objective exercise of a certified application counselor's or certified application counselor organization's official duties (see 77 FR 18330–31). In an FFE, we interpret ''other potential conflicts of interest'' to encompass any relationship with a certified application counselor which may have an influence on the information or scope of assistance being provided to the consumer during the course of the certified application counselor's assistance or any relationship that would confer benefits or indirect financial gain that could potentially compromise a certified application counselor's ability to act in the best interests of the consumer.

We also propose to add a new § 155.225(g)(3), which would prohibit individual certified application counselors from being compensated on a per-application, per-individual-assisted, or per-enrollment basis. As with Navigators and non-Navigator assistance personnel, we believe that in order for application and enrollment assistance to be effective and appropriate for each consumer, per-enrollment or per-application incentives that might encourage certified application counselors to rush through sessions with consumers, or not to provide them with complete information or enough time to make complex and important health coverage decisions, should not be permitted. Such incentives would impede a certified application counselor's ability to act in the best in the best interests of consumers, as they are required to do under § 155.225(d)(4). This proposal would also help streamline requirements for these three types of assistance personnel. We seek comment on this proposal and alternatives that build in rewards for performance without the unintended consequences previously described.

We also propose to add a new paragraph (g)(4) to prohibit certified application counselors from providing applicants or potential enrollees any gifts, including gift cards or cash, unless they are of nominal value. As we also proposed in our earlier discussion with respect to Navigators, we propose to define nominal value consistent with the definition used for nominal value in connection with prohibitions applicable to the marketing of Medicare Advantage and Medicare Part D plans. (See 73 FR 54236) Specifically, nominal value would be defined as a cash value of $15 of less, or an item worth $15 or less, based on the retail purchase price of the item regardless of the actual cost. CMS proposes that it would update the definition of nominal value in guidance as necessary to account for inflation and other relevant factors. We seek comment on how nominal value should be defined in this context. We also propose in this section to prohibit certified application counselors from providing applicants and potential enrollees with promotional items that market or promote the products or services of a third party, in connection with, or as an inducement for application assistance or enrollment. We are proposing this prohibition for certified application counselors for similar reasons to those expressed above in connection with the prohibition in the Navigator and non-Navigator assistance programs. We are concerned that the provision of cash or gifts to potential applicants or enrollees might interfere with the duties of the individual providing assistance to that applicant or potential enrollee; and in the case of a certified application counselor, might shift the focus of a certified application counselor's interaction with a potential applicant or enrollee away from the certified application counselor's duties to act in the consumer's best interest and to

facilitate selection of a QHP. In addition, if a certified application counselor provides promotional items that market or promote the products or services of a third party, this too would conflict with the duty of a certified application counselor to act in the best interest of the consumer, since it introduces a third party's interests and marketing goals into the relationship between the certified application counselor and the consumer they are assisting and may also cause consumers to approach certified application counselors for reasons unrelated to the receipt of information and Exchange application assistance.

In proposed section § 155.225(g)(5), we would establish a standard for certified application counselors that would prohibit them from soliciting consumers for application or enrollment assistance by going door-to-door to provide this assistance, or to use other unsolicited means of direct contact, including calling a consumer, to provide application or enrollment assistance without the consumer initiating the contact. We also propose in a new § 155.225(g)(6) to prohibit certified application counselors from making robocalls to consumers, such as those that are initiated to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice. As we explained earlier in this preamble in relation to the parallel proposed standard for Navigators and non-Navigator assistance personnel, we believe restrictions on door-to-door solicitation and cold-calling would ensure that certified application counselors use practices that are protective of the privacy and security interests of the consumers they serve, and give those consumers the greatest peace of mind. We also believe that these standards would provide important guidance to consumers about what to expect in their interactions with certified application counselors. As with the parallel proposal for Navigators and non-Navigator assistance personnel, we clarify that this proposal would not prohibit a certified application counselor from going door-to-door to provide consumers with information about the availability of application assistance services, or other educational or outreach materials,[35] We seek comment about whether any of the activities and strategies that we propose to prohibit are appropriate and consistent with Federal requirements.

We solicit public comments on all aspects of these proposals.

d. Payment of Premiums (§ 155.240)

There are a limited number of circumstances in which an individual will be enrolled in a qualified health plan through the Exchange for less than a full month. In particular, these include situations in which a child is born, adopted, placed for adoption, or placed for foster care, or when an individual voluntarily terminates enrollment. Currently, there are no Federal standards for how premiums are prorated in these limited situations. In order to provide flexibility for Exchanges to establish a standardized methodology for partial month premiums or rely on issuers to prorate premiums in accordance with State law and issuer policies, we propose in § 155.240(e) that the Exchange may establish one or more standard processes for premium calculation. Further, consistent with the methodology finalized for the FF–SHOP at § 155.705(b)(4)(ii)(B) in the 2015 Payment Notice, in paragraph (e)(1), we propose that for the Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of the premium for one month of coverage divided by the number of days in the month and the number of days for which coverage is being provided in the month described in paragraph (e)(1)(i) of this section. Adopting this policy for the Federally-facilitated Exchange will address situations in which enrollees have mid-month changes in enrollment. For example, the proposed policy will also address mid-month births or adoptions and prevent these enrollees from paying for coverage on days they were not enrolled in coverage. In addition, the proposed policy will eliminate issues where consumers who transition to Medicaid are charged premiums for days on which they are enrolled in Medicaid. Although it is not a new occurrence for consumers to transition from private health insurance to Medicaid without the benefit of premiums that are prorated precisely to the last day of private health insurance and the first day of Medicaid coverage, we anticipate that the expansion of private health insurance through the Exchange will increase the number of individuals who will be able to move between coverage types. We believe that the proposed policy will benefit this broadening group. This policy will also be consistent with proposed 26 CFR 1.36B–3(d)(2), which specifies that when coverage is terminated before the last day of the month, and the issuer reduces or refunds a portion of the monthly premium, the premium tax credit is adjusted using the same methodology described in this regulation for the FF–SHOP. Aligning with the premium tax credit calculation will provide a cohesive policy across the Federally-facilitated Exchange for handling mid-month changes in enrollment, and will simplify the calculation of net premiums. Finally, the proposed Federally-facilitated Exchange policy will protect consumers and prevent them from paying premiums for days in which they are not enrolled in coverage. We intend to work closely with QHP issuers to implement this provision in the Federally-facilitated Exchange as soon as is reasonably possible.

We seek comment on this proposed amendment.

e. Privacy and Security of Personally Identifiable Information (§ 155.260)

We propose amending § 155.260(g) to add a reference to § 155.285, which is being proposed as part of this proposed rule. Section 155.285 proposes to specify the grounds for imposing civil money penalties, the notice required to be given to a person when a civil money penalty is assessed, and factors to be used to determine the amount of civil money penalties assessed, as well as some aspects of the process for imposing civil money penalties. We propose this addition to § 155.260(g) to clearly link these two regulatory provisions and to ensure that readers fully understand how civil money penalties will be assessed for any improper use or disclosure of information.

f. Bases and Process for Imposing Civil Money Penalties for Provision of False or Fraudulent Information to an Exchange or Improper Use or Disclosure of Information (§ 155.285)

Section 1411 of the Affordable Care Act sets forth the procedures for determining eligibility for Exchange participation, premium tax credits and reduced cost-sharing, and the individual responsibility exemptions. Section 1411(b) specifies minimum information required to be provided by an applicant, including name, address, date of birth, social security number (if applicable, based on the applicant's citizenship or immigration status), and immigration status. For applicants seeking eligibility for advance payment of the premium tax credit or cost sharing reductions, section 1411(b) also specifies that the applicant must provide information regarding income and family size, and information regarding employer sponsored coverage.

[35] We note that certified application counselors are not required to perform outreach activities. (see 78 FR 42826).

For applicants for an exemption from the shared responsibility payment for failure to maintain minimum essential coverage, section 1411(b) also requires submission of information relevant to the specific exemption sought by the applicant. In addition, section 1411(g) of the Affordable Care Act also requires that any person who receives information provided by an applicant under section 1411(b), whether directly from the applicant, by another person at the request of the applicant, or from a Federal agency may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange. Finally, section 1411(h) specifies the civil money penalties which can be imposed for the provision of false or fraudulent information as well as for the improper use and disclosure of information. In § 155.285, we propose to regulate on this statutory authority to impose civil money penalties for the provision of false and fraudulent information in violation of section 1411(h)(1) of the Affordable Care Act and the improper use and disclosure of information in violation of section 1411(g) of the Affordable Care Act.

In § 155.285(a), in accordance with the grounds on which penalties may be imposed as specified in section 1411(h) of the Affordable Care Act, we propose the circumstances in which HHS may impose civil money penalties (CMPs) on a person if HHS determines that the person has provided false or fraudulent information as prohibited by section 1411(h)(1) or improperly used or disclosed information in violation of section 1411(g). We want to ensure that any person who does not comply with relevant statutory and regulatory provisions, which limit the ways in which information provided by an applicant or from a Federal agency can be used, may be appropriately penalized. HHS may impose CMPs for three specific types of actions related to the provision of false or fraudulent information and the improper use of information. HHS intends to work in collaboration with States to oversee, monitor, and enforce compliance with § 155.285 in order to protect consumers, avoid duplication of efforts, and provide consistent enforcement practices.

Section 1411(b) specifies the information that is required to be provided by an applicant for enrollment in a QHP offered through an Exchange in the individual market, for premium tax credits or cost sharing reductions, or for an exemption from the individual shared responsibility payment based on the individual's status as a member of an exempt religious sect or division, as an Indian, or as an individual eligible for a hardship exemption, or based on the individual's lack of affordable coverage or the individual's status as a taxpayer with household income less than 100 percent of the poverty line. In § 155.285(a)(1)(i), we propose that if any person (as defined at proposed § 155.285(a)(2)) fails to provide correct information under section 1411(b) of the Affordable Care Act and such failure is attributable to negligence or disregard of any regulations of the Secretary, the person may be subject to a CMP. For purposes of this subsection, the terms ''negligence'' and ''disregard'' have the same meaning as those in section 6662 of the Code. Thus, we propose that ''negligence'' includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information, and the term ''disregard'' includes any careless, reckless, or intentional disregard for any rules or regulations of the Secretary. Under proposed § 155.285(a)(1)(i), if a person fails to make a reasonable attempt to provide accurate, complete and comprehensive information and as a result provides incorrect information, the person may be subject to a CMP.

Second, in § 155.285(a)(1)(ii), we propose that if a person knowingly and willfully provides false or fraudulent information under section 1411(b) of the Affordable Care Act, the person may be subject to a CMP. Here, HHS must find that a person provided false or fraudulent information ''knowingly and willfully.'' This provision aims to ensure that any person who intentionally provides information required under section 1411(b) of the Affordable Care Act that the person knew to be false could be subject to a CMP. In addition, if consumer assistance personnel such as an agent, broker, Navigator, certified application counselor, or non-Navigator assistance personnel, were to in some manner directly provide false or incorrect information required under section 1411(b), they may also be subject to a CMP. If consumer assistance personnel subject to § 155.206 of this subpart were to engage in this type of behavior, we propose that it should be left to HHS' discretion to determine whether it was appropriate to impose a CMP under this regulation, or under § 155.206 of this subpart, if applicable. We note that § 155.206 would only apply to Navigators, certified application counselors, and non-Navigator assistance personnel in a Federally-facilitated Exchange and that violations of § 155.285 may not necessarily also constitute violations of § 155.206. In such instances where consumer assistance personnel may be subject to a CMP under both §§ 155.206 and 155.285, we have considered specifying that HHS may only impose a CMP under § 155.285. However, we propose that it should be left to HHS' discretion to determine whether it would be appropriate to impose a CMP under § 155.206 or § 155.285. We seek comment on this proposal and whether any alternative approaches should be used.

Third, in § 155.285(a)(1)(iii), we propose that if a person knowingly and willfully uses or discloses information in violation of Affordable Care Act section 1411(g), the person may be subject to a CMP. Section 1411(g) of the Affordable Care Act specifies that any person who receives information required to be provided by an applicant, whether the person receives the information directly or by another person at the request of the applicant, or receives information from a Federal agency that has been verified as being consistent or inconsistent with the records of that Federal agency, may use the information only for the purposes of, and to the extent necessary in, ensuring the efficient operation of the Exchange. We will refer to the personally identifiable information (PII) described in the previous sentence as ''Exchange PII'' for the purposes of this section. Section 1411(g) of the Affordable Care Act also specifies that any person who receives Exchange PII may not disclose the information to any other person except as provided in section 1411 of the Affordable Care Act. Section 155.260(a)(1) and (2) implement section 1411(g) of the Affordable Care Act by specifying that an Exchange may only use or disclose Exchange PII to carry out the functions described at § 155.200 or to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange and for which the individual has provided consent for his or her information to be so used or disclosed.

In § 155.285(a)(1)(iii)(A) through (C), we propose types of activities that would be in violation of section 1411(g) of the Affordable Care Act. Because § 155.260 further describes the limitations on the use and disclosure of Exchange PII, we propose that any use or disclosure of Exchange PII that violates relevant privacy and security standards established by the Exchange pursuant to § 155.260 of this subpart may constitute a violation of section 1411(g) of the Affordable Care Act. We also propose that any other use or disclosure that has not been determined by the Secretary to ensure the efficient

operation of the Exchange be compliant with section 1411(g)(2)(A) of the Affordable Care Act pursuant to § 155.260(a), and which is not necessary to carry out a function described in a contract with a non-Exchange entity executed pursuant to § 155.260(b)(2) of this subpart, may constitute a violation of section 1411(g) Affordable Care Act. More specific examples of activities that would violate section 1411(g) Affordable Care Act include a person selling lists of Exchange PII belonging to individuals who apply for enrollment or enroll in an Exchange qualified health plan, or a non-Exchange entity using the PII of individuals who sought enrollment in an Exchange qualified health plan to market products or services to those individuals. We note that without the express, specific consent of the consumer for their PII to be used for marketing purposes, use of Exchange PII for marketing purposes is prohibited by section 1411(g). In addition, we note that any person who obtains specific consent from an applicant or enrollee to use PII for marketing purposes must clearly inform the applicant or enrollee that the marketing activities have no relationship to or bearing on an eligibility determination for or enrollment in the Exchange. To the extent any person plans to obtain such consent to market products to Exchange applicants and enrollees, the person should be prepared to provide proof of consent upon request by the agency during the course of the agency's normal oversight activities.

In § 155.285(a)(2), we propose a definition of the term ''person.'' We propose that for purposes of this regulation, the term ''person'' should be defined to include, but should not be limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to PII submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to 155.260(a)(1); and non-Exchange entities as defined in § 155.260(b) of this subsection, which includes agents, brokers, Web-brokers, QHP issuers, Navigators, certified application counselors, in-person assistors, and other third party contractors. The term ''person'' would also include the employees of the aforementioned entities. We propose to define the term very broadly because there are several different types of individuals and entities that could engage in the actions enumerated in § 155.285(a)(1), and we hope to ensure that all such individuals and entities are aware of the penalties they could incur. We seek comment on these proposals.

In § 155.285(b), we propose the factors that HHS may take into consideration when determining the amount of CMPs to impose. We propose in § 155.285(b)(1) that HHS may take into account factors that include, but are not limited to, the following factors: the nature and circumstances of the conduct including the number of individual violations; the severity of the violations; the person's history with the Exchange, including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior; the length of time during which the violation(s) occurred; the number of individuals affected or potentially affected; and the extent to which the person received compensation or other consideration associated with the violation. We also propose in § 155.285(b)(2) that HHS take into account the nature and extent of the harm resulting from the action, including the number of individuals affected; whether the violation resulted in financial harm; whether there was harm to an individual's reputation; whether the violation hindered or could have hindered an individual's ability to obtain health care coverage; the actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of information; and whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reduction than he or she would be eligible for if the correct information had been provided.

In § 155.285(b)(3), we implement the reasonable cause exception of section 1411(h)(1)(A)(ii) of the Affordable Care Act pursuant to which no penalty will be imposed under § 155.285(a)(1)(i) if HHS determines that there was a reasonable cause for the failure to provide correct information required on an Exchange application and that the person acted in good faith. We feel that this reasonable cause exception is very important to ensure that no CMP may be imposed for a situation in which a person was acting in good faith.

In § 155.285(c), we propose maximum penalties for each different type of violation, in accordance with the statutory limitations set forth in section 1411(h) of the Affordable Care Act. Section 155.285(c)(1) addresses maximum penalties for provision of incorrect information, where such failure is attributable to negligence or disregard of any rules or regulations of the Secretary, and for knowing and willful provision of false or fraudulent information in violation of section 1411(h) of the Affordable Care Act. We propose that the maximum penalty may be imposed on a per application basis, as defined at proposed § 155.285(c)(1)(iii), during a single ''plan year.'' We propose to use the definition for ''plan year'' at § 155.20, where a ''plan year'' means a consecutive 12 month period during which a health plan provides coverage for health benefits and which may be a calendar year or otherwise. In § 155.285(c)(1)(i), we propose that any person who fails to provide correct information as specified in § 155.285(a)(1)(i) may be subject to a maximum CMP, as specified in section 1411(h)(1)(A)(i) of the Affordable Care Act, for each ''application'' on which the person fails to provide correct information. In § 155.285(c)(1)(ii), we propose that any person who knowingly and willfully provides false information as specified in § 155.285(a)(1)(ii) may be subject to a maximum CMP, as specified in section 1411(h)(1)(A)(i) of the Affordable Care Act, for each application on which the person knowingly and willfully provides false information. Since we are proposing that we would impose a penalty on a plan year basis, if a person were to elect to use the same information which he or she entered on an initial application for the subsequent plan year, and the person had knowingly and willfully entered false information on an application as described in § 155.285(c)(1)(ii), the person may be subject to two CMPs, each up to the maximum CMP specified in section 1411(h)(1)(A)(i) of the Affordable Care Act, based on the provision of false information for two plan years.

In § 155.285(c)(1)(iii), we propose that for the purposes of this subsection, an ''application'' is defined as a submission of information whether submitted through an online portal, over the telephone through a call center, or through a paper submission process. This submission of information is provided in relation to any of the following: An eligibility determination; an eligibility redetermination based on a change in an individual's circumstances; or an annual eligibility redetermination for either enrollment in a qualified health plan, for premium tax credits or cost sharing reductions, or for an exemption from the individual shared responsibility payment. By proposing this definition of application, we intend for each submission of information, regardless of the means of

submission, to be considered a distinct application. For example, where a person submits an initial application for enrollment in a QHP, and later updates his or her information to reflect a change in circumstance, we propose that this person would have submitted two applications. We anticipate that there may be situations where a person submits a false piece of information on an initial application for coverage, and this false information could be seen as re-submitted on a second application in the same plan year. We propose to provide HHS flexibility in such situations as that described above so that HHS may, in its discretion, and depending on the particular facts of the case, determine the number of incorrect pieces of information submitted, and therefore determine the appropriate penalty for this situation. We solicit comment on this proposal as well as on alternate methods through which HHS could determine the appropriate amount of penalties to impose.

In § 155.285(c)(2), we propose that any person who knowingly or willfully uses or discloses information as specified in § 155.285(a)(1)(iii) may be subject to a CMP. We propose in § 155.285(c)(2)(i) that a person may be subject to a maximum CMP, as specified in section 1411(h)(2) of the Affordable Care Act, for each use or disclosure described in paragraph (a)(1)(iii) of this section, per use or disclosure. We also propose to define, in § 155.285(d)(2)(ii) that a use or disclosure includes one separate use or disclosure of a single individual's PII that the person against whom a civil money penalty may be imposed has made. For example, if an agent were to sell a list of 100 consumers' names and other identifiable information to another entity, the proposed definition of a use or disclosure would mean that HHS could impose a total of 100 CMPs, each with a maximum penalty of the amount specified in section1411(h)(2) of the Affordable Care Act because the agent had disclosed the PII of 100 individuals. In § 155.285(c)(3), we also propose that these penalties may be imposed in addition to any other penalties that may be prescribed by law.

In § 155.285(d), we propose standards for a notice of intent to issue a CMP that HHS must send to the person against whom the CMP is being imposed. We propose that the written notice will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. In § 155.285(d)(1)(i)–(viii), we propose eight elements that must be included in the notice. The elements which must be included are as follows: (1) A description of the findings of fact regarding the violations with respect to which the CMP is proposed; (2) the basis and reasons why the findings of fact subject the person to a penalty; (3) any circumstances described in § 155.285(c) that were considered in determining the amount of the proposed penalty; (4) the amount of the proposed penalty; (5) an explanation of the person's right to a hearing under any applicable administrative hearing process; (6) a statement that the failure to request a hearing within 60 calendar days after the date of the notice permits the assessment of the proposed penalty; and (7) information explaining how to file a request for a hearing and the address to which the hearing request must be sent. We propose that the person may request a hearing before an ALJ on the proposed penalty by filing a request pursuant to the procedure that will be outlined in the notice of intent to issue a penalty that the person receives.

In § 155.285(e), we propose the consequences for a person who fails to request a hearing in a timely manner. We propose that HHS may assess the proposed CMP 60 calendar days after the date of issuance printed on the notice of intent to issue a CMP. In § 155.285(e)(1), we propose that HHS will notify the person in writing of any penalty that has been imposed, the means by which the person can satisfy the penalty, and the date on which the penalty is due. We propose in § 155.285(e)(2) that a person has no right to appeal a penalty with respect to which the person has not timely requested a hearing. We believe 60 days is a sufficient period for a person to request a hearing. We seek comment on these proposals.

In § 155.285(f), we propose to use the existing appeals framework in regulation at 45 CFR Part 150, Subpart D. We propose to exclude §§ 150.461, 150.463, and 150.465 based on their lack of applicability to § 155.285. In § 155.285(g), we propose that CMS and OIG will share enforcement authority to impose the CMPs in § 155.285. In § 155.285(g)(1), we propose that CMS may impose CMPs for any of the violations at § 155.285(a). In § 155.285(g)(2), we propose that OIG may impose CMPs for violations specified at § 155.285(a)(1)(ii) and (iii) in place of imposition of penalties by CMS. We believe OIG has the investigative capabilities which would be necessary to determine whether a person performed an action knowingly and willfully, a finding which would be required before imposing a CMP for the violations specified at § 155.285(a)(1)(ii) and (iii). In light of our proposal to allow OIG to impose CMPs for violations specified at § 155.285(a)(1)(ii) and (iii), we anticipate that OIG would amend its regulations at part 1003 of Chapter V of title 42 to encompass the standards set forth in this section. We seek comment on the proposed use of the regulatory framework for appeals at 45 CFR Part 150, Subpart D and on the question of whether any other regulatory framework used by HHS for appeals presents a more appropriate framework.

In § 155.285(h), we propose a settlement authority provision to ensure CMS is able to settle any issue or case described in § 155.285(a) if necessary. Finally, in § 155.285(i), we propose a six year statute of limitations, beginning from the date on which the violation occurred, within which HHS may impose a CMP against a person. We seek comment on the proposed 6 year statute of limitations.

3. Subpart D—Exchange Functions in the Individual Market: Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. Verification of Eligibility for Minimum Essential Coverage Other Than Through an Eligible Employer-Sponsored Plan (§ 155.320)

In § 155.320(d)(4), we established an option under which a State Exchange could rely on HHS to conduct verifications of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan for purposes of eligibility for advance payments of the premium tax credit. This option was made available for eligibility determinations that are effective on or after January 1, 2015. Under this option, a State Exchange would need to develop an interface through which to transfer information to HHS, HHS would need to develop a way to receive and process the information, check data sources, potentially communicate with consumers, and then return information to the State Exchange, and the State Exchange would need to modify systems to integrate this response into what should otherwise be a near-real-time eligibility process. Responsibilities for customer service would likely be split across the State Exchange and HHS, which would be difficult to coordinate and increase administrative costs.

Accordingly, we have determined that the benefit gained by having HHS provide this function is far outweighed

by the information technology development and administrative and consumer complexity that would be introduced for a State through this approach. As such, we propose to strike paragraph (d)(4). We remain committed to working with State Exchanges to develop effective solutions for verifying enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan, and will work to make any additional electronic data sources that are accessible to HHS equally available to State Exchanges. We note that this proposed modification does not change the substantive rules regarding the verification of enrollment in an eligible employer-sponsored plan and eligibility for qualifying coverage in an eligible employer-sponsored plan. Therefore, the change does not affect program integrity.

b. Eligibility Redetermination During a Benefit Year (§ 155.330)

We propose a technical correction in paragraph (d)(2)(ii) to remove the reference to paragraph (e)(3) of this section. In the final rule titled, ''Medicaid and Children's Health Insurance Programs: Essential Health Benefits in Alternative Benefit Plans, Eligibility Notices, Fair Hearing and Appeal Processes, and Premiums and Cost Sharing; Exchanges: Eligibility and Enrollment'', 78 FR 32319, we previously removed paragraph (e)(3) from this section. As such, we now clarify that paragraph (d)(2)(ii) should only refer to the standards specified in paragraph (e)(2) of this section.

4. Subpart E—Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

a. Enrollment of Qualified Individuals in a QHP (§ 155.400)

In § 155.400, we propose to add paragraph (e). In this paragraph, we propose to establish that the Exchange would provide instructions to issuers regarding payment of the first month's premium for enrollments. Additionally, in § 156.265 we propose to establish a requirement for issuers in the Federally-facilitated Exchanges regarding payment due dates to collect premiums no later than the day before the coverage effective date. Our intention is to give the Exchange the flexibility to establish policy and process rules regarding premium payment.

We also propose to add paragraph (f), which would authorize Exchanges to provide requirements to QHP issuers regarding the instructions for processing electronic enrollment-related transactions.

b. Initial and Annual Open Enrollment Periods (§ 155.410)

In 45 CFR 155.410(d), we specify that starting in 2014, the Exchange must provide a written annual open enrollment notification to each enrollee no earlier than September 1, and no later than September 30. In 45 CFR 155.335(d), we specify that notice of annual redetermination for coverage effective January 1, 2015 be provided as a single, consolidated notice with the notice specified in 45 CFR 155.410(d). In the 2015 Payment Notice, we amended 45 CFR 155.410(e) to specify that for the benefit year beginning on January 1, 2015, the annual open enrollment period begins on November 15, 2014. Accordingly, we believe that it is appropriate to modify the timing of the notice of annual open enrollment and annual redetermination. Two options we could consider for this notice include, but are not limited to: (1) Shifting the period during which the notice would be sent by a month, so that the notice would be sent no earlier than October 1, and no later than October 31; and (2) shifting the period during which the notice would be sent by a month and lengthening this period so that the notice would be sent no earlier than October 1, and no later than November 15, provided that electronic notices are available for any consumer who contacts the Exchange on November 15. We solicit comment on which of these options we should implement, or if we should implement another option.

c. Special Enrollment Periods (§ 155.420)

In 45 CFR 155.420, we set forth provisions for special enrollment periods. We now propose amending § 155.420(b)(2)(ii), (d)(1), (d)(6)(iii) and (e), which pertain to the special enrollment period for loss of coverage; § 155.420(b)(2)(i) and (iii), which pertain to effective dates for certain special enrollment periods; and § 155.420(c), to address the length of the special enrollment periods.

In paragraph (b)(2)(i), we propose to provide flexibility for coverage effective dates in the case of birth, adoption, placement for adoption, or placement in foster care. We continue to require the Exchange to ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care, but we allow Exchanges to permit the qualified individual or enrollee to elect a later coverage effective date. If the Exchange permits the qualified individual or enrollee to elect a later coverage effective date, the Exchange must ensure coverage is effective on the date elected by the qualified individual or enrollee. We are considering establishing parameters for the dates that may be chosen by the qualified individual or enrollee.

In § 147.104(b)(2), we specified that, ''a health insurance issuer in the individual market must provide, with respect to individuals enrolled in non-calendar year individual health insurance policies, a limited open enrollment period . . .'' Accordingly, in order to align Exchange regulations with those of the broader insurance market, in paragraph (d)(1), we propose that the Exchange permit qualified individuals and their dependents to enroll in or change from one QHP to another if they are enrolled in a non-calendar year individual health insurance policy in 2014 described in § 147.104(b)(2), even if such non-calendar year policies are renewing. Thus, consumers whose individual health insurance policies that renew outside the Exchange open enrollment period have an opportunity to enroll in an Exchange, just as they would if their policies renewed during the Exchange open enrollment period. Without this addition, consumers with individual health insurance policies renewing outside the Exchange open enrollment period would be required to renew such policies, and wait to terminate the policies during the Exchange open enrollment period, should they wish to enroll in the Exchange, thus disadvantaging these consumers as compared to consumers enrolled in calendar year individual market policies.

In 26 CFR 1.5000A–2(b)(1)(ii)(C), the Secretary of the Treasury specified that coverage of pregnancy-related services under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)) was not minimum essential coverage. In order to ensure that women losing eligibility for coverage of pregnancy-related services as described above are not left without an option to enroll in a QHP after the conclusion of Medicaid eligibility, in paragraph (d)(1), we propose that the Exchange permit qualified individuals and their dependents to enroll in a new QHP if they lose eligibility for such pregnancy-related services. We note that HHS may designate certain specific pregnancy-related programs to be minimum essential coverage under section 5000A(f)(1)(E) of the Affordable Care Act, though we propose to require this special enrollment period, regardless. We solicit comments

regarding whether there are other situations in which an individual loses coverage that is not defined as minimum essential coverage, such as AmeriCorps coverage, and should be provided with a special enrollment period.

We propose to add to paragraph (c) to specify that the Exchange must permit qualified individuals and their dependents to access the special enrollment periods described in paragraph (d)(1) for up to 60 days prior to the end of the qualified individual's or his or her dependent's existing coverage. This is consistent with existing regulations in paragraph (d)(6)(iii) that are specific to an individual who is enrolled in an eligible employer-sponsored plan who is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible employer-sponsored plan. To improve the clarity and structure of this rule, we propose to move the language in paragraph (d)(6)(iii) regarding the 60 days prior access to the SEP to paragraph (c). The proposed change, to paragraph (d)(1) that would expand the ability to report a change in advance to all individuals who are described in paragraph (d)(1) is designed to allow an individual who is losing eligibility for coverage outside the Exchange to transition to coverage offered through an Exchange without a gap in coverage, but with protections to ensure that advance payments of the premium tax credit are not provided in advance of the loss of eligibility for minimum essential coverage outside the Exchange. Accordingly, we note that individuals are not eligible for advance payments of the premium tax credit until they are no longer enrolled in minimum essential coverage outside the Exchange. Lastly, we propose to make conforming changes to paragraphs (b)(2)(ii) and (e) to align with the changes in terminology proposed in paragraph (d)(1).

In paragraphs (d)(4), (d)(5), (d)(9) and (d)(10), we provide special enrollment periods for errors, contract violations, exceptional circumstances and misconduct. Existing paragraph (b)(2)(iii) specifies that for a plan selection made during one of the special enrollment periods under paragraphs (d)(4), (d)(5), and (d)(9), coverage must be effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS, and provides two options for that effective date. We propose to add special enrollment periods triggered under paragraph (d)(10) to those special enrollment periods for which these special coverage effective dates are available. In order to ensure that the Exchange has sufficient flexibility with which to address the types of scenarios that may trigger these special enrollment periods, we propose to amend paragraph (b)(2)(iii) to remove the restriction to these two options. The resulting regulatory text would allow the Exchange to set an effective date based on what is appropriate to the circumstances, in accordance with any guidelines issued by HHS. Similarly, in order to ensure that the Exchange sets the length of these same special enrollment periods to be appropriate to the circumstances of the specific enrollment period, we propose to modify paragraph (c) to specify that the Exchange may define the length of these special enrollment periods as appropriate based on the circumstances of the special enrollment period, in accordance with any guidelines issued by HHS. We believe that this flexibility is important to ensure that the special enrollment periods can be implemented as intended.

Section 155.420(e) clarifies what qualifies as loss of coverage for purposes of the special enrollment period described in paragraph (d)(1). We propose to modify this paragraph to clarify that voluntary termination does not qualify as loss of coverage for purposes of a special enrollment period, since the intent of this special enrollment period is to ensure that an individual who is losing coverage can transition to the Exchange without interruption, and not to allow an individual to switch from another form of coverage to the Exchange during the year when the other form of coverage remains available and he or she does not qualify for another special enrollment period described in this section. We solicit comments regarding this clarification.

d. Termination of Coverage (§ 155.430)

We propose to add paragraph (e) to § 155.430 to establish the difference between a termination and a cancellation and establish the significance of a reinstatement action in the context of QHP coverage offered through an Exchange. Specifically, we propose to specify that a cancellation is a specific type of termination action taken either prior to or after the effective date of coverage that ends a qualified individual's coverage on or before the effective date, thus rendering coverage as never effective. In contrast, a termination is an action taken after the effective date of coverage that ends an enrollee's coverage effective on a date after the coverage effective date. In a cancellation, the effect of the QHP's action would be that a qualified individual never receives coverage from the QHP, whereas in a termination the QHP covers the enrollee for some period of time and would be liable for covered services that the enrollee received during the time period between the coverage effective date and the termination date, under the terms of the coverage. A reinstatement action is a correction of an erroneous termination or cancellation action resulting in restoration of an enrollment with no break in coverage.

In addition to establishing the difference between cancellations and terminations, we also propose that an Exchange may establish operational standards for QHP issuers for implementing terminations, cancellations, and reinstatements. Enrollment systems for both SBEs and the FFE continue to evolve, and we believe that the Exchange's ability to issue operational instructions will enable both the Exchange and the issuer community to respond more effectively to changing systems and changing processes. We believe the effectiveness of this approach has been demonstrated in other programs administered by CMS, specifically the Medicare Advantage and Medicare Part D programs.

Further, we are proposing to clarify in paragraph (d)(6) that the termination effective date being the day before the effective date of coverage in the new QHP would also apply in cases of retroactive enrollments. This could occur when a consumer is granted a special enrollment period to change QHPs with a retroactive coverage effective date under 155.420(b)(2)(iii). For coverage that is terminated retroactively, CMS will adjust any applicable payments to the original QHP issuer based on the retroactive termination date, in order to recoup any advance payments of the premium tax credit and cost-sharing reductions made to the former issuer for the enrollee. The Exchange would be required to ensure that the former issuer refunds or credits any premium paid to the issuer by the enrollee, reversing claim payments, and ensuring the provision of refunds for out-of-pocket payments made by or for the enrollee for covered benefits and services incurred, during the retroactive coverage period. We seek comment on whether to add a specific requirement to this effect on issuers in Part 156.

Conversely, in the case of a retroactive coverage date, CMS will provide the gaining issuer any applicable advance payments of the premium tax credit and

cost-sharing reductions based on the retroactive coverage effective date. Cost-sharing reduction reconciliation will occur for all cost-sharing reductions provided beginning with the retroactive coverage date. The gaining issuer would collect the enrollee's portion of the premium for all months of coverage and will be required to adjudicate the enrollee's claims incurred during the retroactive period, and provide any applicable cost-sharing reductions.

5. Subpart F—Appeals of Eligibility Determinations for Exchange Participation and Insurance Affordability Programs

a. General Eligibility Appeals Requirements (§ 155.505)

In § 155.505, we propose a technical correction to paragraph (b)(4) by removing ''; and'' at the end of the paragraph and adding a period in its place.

b. Dismissals (§ 155.530)

In § 155.530, we propose to amend paragraph (a)(1) to provide an additional method for appellants to withdraw appeal requests. The existing provision requires an appellant who wishes to withdraw his or her appeal request to do so in writing (hard copy or electronic). We are proposing to include the alternative for an appellant to withdraw his or her appeal by telephone, if the appeals entity is capable of accepting telephonic withdrawals. In paragraphs (a)(1)(i)(A) and (B), we propose the requirements for providing a telephonic withdrawal process. Specifically, we propose that the appeals entity must record in full the appellant's statement and telephonic signature made under penalty of perjury, and provide a written (in hard copy or electronically) confirmation to the appellant documenting the telephonic interaction. This written confirmation can be captured in the dismissal notice required in the case of a withdrawal under § 155.530(b). We note that a telephonic signature is a verbal acknowledgement in place of a written signature.

The intent of this proposed amendment is to provide a more efficient and convenient method for appellants and appeals entities to conclude an appeal at the request of the appellant. For example, under the current rules, an appeals entity must keep an appeal open and proceed to hearing following an informal resolution in every case where the appellant has not communicated his or her wish to withdraw the appeal in writing, even if the appellant is satisfied with the informal resolution decision. Because we anticipate that many appellants will not take the step of withdrawing their appeal requests in writing in this scenario, we believe the proposed amendment will provide appellants an easier process through which they can indicate their wish to end the appeals process. In addition, we believe the proposed amendment will also benefit appeals entities by reducing administrative burden, such as the requirement to convene unnecessary hearings described in the example above. The telephonic signature process provides a verifiable record of the appellant's intention to withdraw the appeal and end the appeals process, including where the appellant is satisfied with a result he or she has obtained without fully exhausting the appeals process.

We request comments on this proposed amendment, including the proposed requirements for accepting telephonic withdrawals. We also note that, although the proposed amendments to this provision will put the Exchange rules for withdrawal of an appeal request out of alignment with the Medicaid fair hearing rules, and we seek comment specifically on the impacts of this proposed change. Finally, we note that this proposed amendment also impacts withdrawal procedures for an employer appeal through the cross-reference in § 155.555(f)(1), which currently requires withdrawals in writing.

c. Employer Appeals Process (§ 155.555)

We propose to amend § 155.555 by redesignating paragraphs (d)(1) through (d)(4) to more clearly delineate between the requirements associated with valid appeal requests versus invalid appeal requests. We note that under this proposed redesignation, paragraph (d)(4) would become new paragraph (d)(2), stating that upon receipt of an invalid appeal request, the appeals entity must promptly and without undue delay send written notice to the employer that the appeal request is not valid because it fails to meet the requirements of this section. New paragraph (d)(2) would also provide introductory language for the requirements provided in paragraphs (d)(2)(i) through (iv). The result of this proposed revisions would be to separate the requirements for valid appeal requests in redesignated paragraph (d)(1) and the requirements for invalid appeal requests in new paragraph (d)(2).

6. Subpart G—Exchange Functions in the Individual Market: Eligibility Determinations for Exemptions

a. Required Contribution Percentage

Under section 5000A of the Code, an individual must maintain minimum essential coverage for each month, qualify for an exemption, or make a shared responsibility payment. Sections 5000A(d) and (e) provide for nine categories of exemptions, and authorize the Secretary to determine individuals' eligibility for some of the exemptions, including the hardship exemption. Sections 1.5000A–3(a) through (h) of 26 CFR enumerate the circumstances in which an individual may be exempt from the shared responsibility payment. These grounds for exemption include: (1) Under 26 CFR 1.5000A–3(e), the individual lacks affordable coverage because the individual's annualized required contribution for minimum essential coverage for the month exceeds the required contribution percentage of the individual's household income; (2) the individual has in effect a hardship exemption certification described in 26 CFR 1.5000A–3(h) and issued by an Exchange, as described in 26 CFR 1.5000A–3(h) and, based on the individual's projected household income, will have no affordable coverage; and (3) the individual and one or more employed members of his or her family has been determined eligible for affordable self-only employer-sponsored coverage through their respective employers, but the aggregate cost of employer-sponsored coverage for all the employed members of the family exceeds 8 percent of household income for that calendar year, as described in 45 CFR 155.605(g)(5). Determining eligibility for these exemptions requires comparison between the individual's share of the costs for obtaining minimum essential coverage and a certain percentage of the individual's household income, actual or projected, for the taxable year. Under section 5000A(e)(1)(A) of the Code, the percentage of the individual's household income is 8 percent. Section 5000A(e)(1)(D) of the Code and 26 CFR 1.5000A–3(e)(2)(ii) further provide that, for plan years beginning in any calendar year after 2014, the percentage is determined by the Secretary to reflect the excess of the rate of premium growth between the preceding calendar year and 2013 over the rate of income growth for the period.

Below, we outline and request comments on issues related to various methodologies we are considering for determining the excess of the rate of

premium growth over the rate of income growth. We are considering publishing the excess of the rate of premium growth over the rate of income growth for calendar years after 2015 in the annual HHS notice of benefit and payment parameters. We are also considering modifying § 155.605(g)(5), which currently sets the required contribution percentage at 8 percent, so that the required contribution percentage for this exemption in future years reflects the required contribution percentage for the applicable calendar year.

Methodology for Determining the Excess of Rate of Premium Growth Over Rate of Income Growth

As one possibility, we are considering establishing the rate of premium growth over the rate of income growth for a particular calendar year as the quotient of (x) one plus the rate of premium growth between the preceding calendar year and 2013, carried out to ten significant digits, over (y) one plus the rate of income growth between the preceding calendar year and 2013, carried out to ten significant digits. (To avoid magnifying rounding errors, any ratio of this sort would also be carried out to ten significant digits.) This would be multiplied by the required contribution percentage for 2014, for ease of application, and the result would be rounded to the nearest hundredth of a percent to yield the required contribution percentage for the calendar year. We note that this methodology would lead to a reduction in the required contribution percentage if the ratio of premium growth to income growth is less than one. Allowing for such a possibility would help ensure that changes in the required contribution standard are proportional to changes in the ratio of premiums over income observed in the private market as a whole. In contrast, we are also considering constraining this ratio, the excess of premium growth over income growth, to be greater than or equal to one. In addition, as discussed in further detail below, we are considering constraining the rate of premium growth and/or the rate of income growth to be equal to or greater than zero in any given year, and seek comment of the impact of these constraints on the excess of the rate of premium growth over the rate of income growth. We welcome comment on approaches for determining the excess of the rate of premium growth over the rate of income growth. In particular, we seek comment on whether the excess of the rate of premium growth over income growth should be calculated based on the difference between the growth rates, the ratio of the growth rates, or through other methods, and whether the result should be subject to other adjustments.

Premium Growth: We are considering setting the rate of premium growth for a calendar year to be the premium adjustment percentage for the year. We provided in the 2015 Payment Notice that the premium adjustment percentage, described at 45 CFR 156.130(e), will be published each year in the HHS notice of benefit and payment parameters, and will be used to adjust certain cost-sharing parameters established by the Affordable Care Act. As discussed in the 2015 Payment Notice, the premium adjustment percentage is calculated based on projections of average per enrollee employer-sponsored insurance premiums from the National Health Expenditure Accounts (NHEA), which are calculated by the CMS Office of the Actuary. After the initial years of implementation of market reforms, once the premium trend is more stable, we may propose to change the methodology for calculating the premium adjustment percentage. For 2015, the premium adjustment percentage is 4.213431463 percent. We note that incorporating the premium adjustment percentage into the methodology for determining the required contribution percentage will ensure that adjustments for premium growth are made in a consistent manner across programs established by the Affordable Care Act. We welcome comment on whether we should use the premium adjustment percentage as a measure of premium growth for the purpose of calculating the contribution percentage index. We also seek comment on whether adjustments, such as ceilings or floors, should be made to that index. For example, we are also considering constraining the rate of premium growth to be equal to or greater than zero in any given year. We note the language of section 5000A(e)(1)(D) of the Code could be read to support such an interpretation. That section uses the term ''premium growth,'' which could be read to mean that the statute envisions an adjustment of the required contribution percentage to only incorporate an increase in premiums. However, for purposes of this calculation, we seek comment on whether growth should be interpreted to refer to both positive and negative growth. We also seek comment on whether other data sources or methods should be used, such as alternative NHEA data sources, premium data from the Federal Employee Health Benefits Program, or any of the data sources discussed in connection with our proposal for the premium adjustment percentage index in the proposed 2015 Payment Notice.

Income Growth: We are contemplating calculating the rate of income growth for a calendar year as the percentage by which the per capita GDP for the preceding calendar year exceeds the per capita GDP for 2013, carried out to ten significant digits. In alignment with the premium adjustment percentage, we are considering using the projections of per capita GDP used for the NHEA.[36] If we were to use the projection of per capita GDP used for the NHEA as a measure of income growth, the rate of income growth for 2015 would be 3.608458790 percent. We note that GDP is a commonly used measure of income growth, but we are also considering other measures of income, such as indices of wages and salaries, and measures of personal income. We welcome comment on our proposed method for calculating the rate of income growth as well as alternative sources of income data that we should consider. In particular, we request comment on whether adjustments should be made to our data source or methodology, such as ceilings or floors. For example, similar to our discussion of ''premium growth'' above, we note that section 5000A(e)(1)(D) of the Code refers to ''the rate of income growth.'' Again, seek comment on whether growth should be interpreted to refer to both positive and negative growth. We also seek comment on whether we should seek to measure growth in GDP per person under the age of 65 or per worker, or growth in some other form of income index only for persons under the age of 65 or per worker, which may align more closely with certain measures of premium growth.

We seek comment on all aspects of these potential approaches.

b. Options for Conducting Eligibility Determinations for Exemptions (§ 155.625)

In § 155.625, we established an option under which a State Exchange could adopt an eligibility determination for an exemption from the shared responsibility payment that was made by HHS, provided that certain conditions were met. Section 1311(d)(4)(H) of the Affordable Care Act specifies that one of the minimum functions of an Exchange is to, ''. . . grant a certification attesting that . . .

[36] *See* Table 1 in *http://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/Downloads/Proj2012.pdf.*

an individual is exempt . . .'' Accordingly, § 155.625(b)(2) specified that under this option, effective October 15, 2014, the Exchange would need to accept the exemption application, transmit it securely to HHS, receive the result, and notify the consumer. This process introduces significant information technology development and administrative burden into a process that could otherwise be executed at a single entity. In particular, such an arrangement would require a split of customer service responsibilities, which could make it very difficult for consumers to navigate the process. It also creates challenges for exemptions that involve information that can only be obtained through the eligibility process for insurance affordability programs, like the cost of the lowest-cost bronze plan net of advance payments of the premium tax credit, which is a component of one of the hardship exemptions described in this subpart, and is only available through a State Exchange.

Accordingly, we propose to revise § 155.625 to remove the option for a State Exchange to adopt an eligibility determination for an exemption from the shared responsibility payment made by HHS for applications submitted on or after November 15, 2014 and, for applications submitted before November 15, 2014, to retain the conditions currently imposed for adopting an eligibility determination for an exemption from the shared responsibility payment that was made by HHS under paragraph (b)(1). Under this proposal, HHS would continue to provide support in this area for applications up until that date. HHS has developed and released a set of model paper applications that can be adopted by State Exchanges, and is committed to providing technical assistance to assist State Exchanges in developing the capability to handle the minimum function of granting certificates of exemption.

7. Subpart H—Exchange Functions: Small Business Health Options Program

a. Functions of a SHOP (§ 155.705) Section 155.705(b)(2) and (3) currently provide that, for plan years beginning on or after January 1, 2015, all SHOPs must make available to qualified employers the option of selecting an actuarial value level of coverage as described in section 1302(d)(1) of the Affordable Care Act and making all qualified health plans at that level available to qualified employees (''employee choice''). Based on communications with issuers and State insurance commissioners, HHS has become concerned that, in some circumstances, implementing employee choice in 2015 might significantly disrupt some small group markets, and might therefore have a negative effect on the ability of small business owners to access coverage. HHS is specifically concerned that in certain circumstances, employee choice might lead to sicker people enrolling in disproportionate numbers in certain plans, which could have the effect of discouraging issuers from participating in the SHOP or causing adverse selection in the market that cannot be fully addressed by the single risk pool provisions of the statute or the premium stabilization programs. We have also heard concerns from issuers and State insurance commissioners that requiring employee choice might reduce issuer participation, leading to minimal value to consumers when there is not broad participation among issuers in the SHOP. At the same time, HHS does not anticipate that these conditions will apply in most markets, and HHS is continuing to work toward implementing employee choice in all SHOPs, because in the long run employee choice will bring significant benefits to small business owners and their employees. Not implementing employee choice may also disrupt the implementation efforts that issuers, States, Exchanges, and other stakeholders have already undertaken.

To address these concerns, we propose to amend § 155.705(b)(2) and (3) to provide for a one year transition policy under which a SHOP would be permitted to not implement employee choice in 2015 under specific circumstances: (1) If employee choice would result in significant adverse selection in the State's small group market that could not be fully remediated by the single risk pool or premium stabilization programs; or (2) if there is an insufficient number of issuers offering qualified health plans or qualified stand-alone dental plans to allow for meaningful plan choice among qualified health plans or qualified stand-alone dental plans for all actuarial value levels in the State's SHOP. We believe that meaningful choice means sufficient competition in the market to allow for participation in the SHOP from multiple issuers throughout the State. Meaningful choice provides affordable, quality plan options throughout the State's SHOP for all actuarial value levels.

Under this proposal, a State regulatory agency, such as the State department of insurance, would submit a recommendation to the SHOP (or in the case of an FF–SHOP, to the Secretary) in support of either circumstance for plan years beginning in 2015. We are considering whether such a recommendation by the State regulatory agency should include a mitigation plan describing the process the State regulatory agency will take to ensure that full implementation of employee choice in 2016 would not result in the occurrence of either aforementioned circumstance, and seek comment on whether such a plan should be included with the recommendation. We expect that the State would be required to provide in the recommendation to the SHOP concrete evidence that employee choice would result in significant adverse selection in the State's small group market that cannot be remediated through the premium stabilization programs or the single risk pool, or that there would not be a meaningful choice of QHPs and/or stand-alone dental plans in the State's SHOP. The SHOP would then evaluate the State's recommendation and request and determine whether the State's small group market would be significantly adversely affected by the implementation of employee choice. In the FF–SHOPs, CMS would seek public comment on the State's request regarding employee choice before making this determination. We seek comment on all aspects of the process SHOPs should follow in making this determination.

We seek comment on all aspects of this proposal, including, but not limited to: (1) The effect of such a policy on all SHOPs; (2) the effect of such a policy on each State's small group market; (3) the effect of such a policy on small employers and their employees and dependents; (4) the information the State regulatory agency should provide in support of any recommendation; (5) the criteria the SHOP (including, in the case of an FF–SHOP, the Secretary) should use in assessing a State regulatory agency recommendation; (6) whether all SHOPs should seek public comment on the State's request regarding employee choice; (7) whether employee choice would have to exist for both medical QHPs and stand-alone dental plans, or for neither; and (8) whether other provisions of the HHS regulations applicable to SHOPs should also be subject to a transition in SHOPs that exercise the proposed option. In particular, we seek comments on what should qualify as a significant risk of adverse selection, what should qualify as a lack of meaningful plan choice, and how both these conditions should be measured.

We also recognize the importance of the timing of a State regulatory agency's recommendation and the SHOP's decision regarding employee choice under this proposal. Whether or not employee choice is available in a SHOP may be relevant information for issuers to consider as they make QHP submissions, but State regulatory agencies also need time to evaluate market dynamics before they can make a recommendation about whether the SHOP should not implement employee choice in 2015. We are considering establishing a deadline for the State regulatory agency's recommendation to the SHOP. One option we are considering is that State regulatory agencies would make recommendations prior to the close of the initial QHP application window, with sufficient time for issuers to decide whether or not to participate in SHOP for the following plan year. Another option would be as follows: (1) All issuers interested in participating in SHOP would apply during the initial application window; (2) state regulatory agencies then would have a specific window of time within which to make a recommendation regarding whether to not implement employee choice in 2015 based on the applications received; (3) the SHOP would then have a specific window of time within which to make a decision about not implementing employee choice in 2015 based on that recommendation; (4) issuers could, based upon the SHOP's decision, decide whether to maintain, modify, or withdraw their QHP applications. In the FF–SHOPs, under this second scenario, we do not anticipate that issuers would be able to submit applications after the initial deadline to apply for QHP certification had passed. We solicit comment on these two options for timing the State regulatory agency's recommendation and the SHOP's decision, and also solicit additional, alternative suggestions for how best to operationalize this proposal. Generally, we request comment on the appropriate time for State regulatory agencies to submit a request to the Exchange regarding employee choice, on the appropriate time for the Exchange to make a decision on those requests, and on the effect of the timing of the decision making process on the QHP certification timeline as described in HHS regulations and guidance (including in the 2015 Annual Issuer Letter).[37] In any event, we expect that SHOPs would reach a decision about employee choice no later than early Fall 2014. We also seek comment on whether adverse selection could be avoided by allowing an employer to provide employee choice under the following circumstances: (1) Within a single issuer's plan offerings within an actuarial value level; (2) for all plans from a single issuer across two contiguous actuarial value levels; and (3) for all plans, all actuarial value levels, from a single issuer. These circumstances are transitional policies and do not reflect the full implementation of employee choice; we seek comment on how the proposed provisions would apply in these circumstances.

b. Enrollment Periods Under SHOP (§ 155.725)

We propose amendments to § 155.725(c) and (e) to amend the dates for the annual open enrollment periods for qualified employers and qualified employees in all SHOPs, both State-based or Federally-facilitated. In proposed §§ 155.725(c)(1), we propose to align the start of annual employer election periods in all SHOPs for plan years beginning in 2015 with the start of open enrollment in the corresponding individual market Exchange for the 2015 benefit year, as amended in the 2015 Payment Notice. In accordance with this proposal, we propose to modify paragraph (e) of this section to remove the reference to a period of no less than 30 days for the annual employee open enrollment period. Under this proposal, the annual employer and employee election periods would begin no sooner than November 15, 2014 with employers making selections first, followed by employees. The employer's annual election period will end when the employer makes relevant decisions about the coming year's participation. Qualified employers and qualified employees would still have adequate time to perform plan selection for plan years beginning in 2015 under this proposal. SHOPs would benefit from having the same amount of time to complete the QHP certification process for the SHOP as they have to complete this process for the individual Exchange. Notification standards described in paragraph (d) and (f) of this section would still apply, as the standards merely require the SHOP to notify qualified employers of annual employer election periods and to notify qualified employees of the annual employee open enrollment periods in advance of such periods.

The lack of alignment of the start of annual employer election periods in the SHOP for plan years beginning in 2015 with the start of open enrollment in the individual market Exchange for 2015 would place a burden on SHOPs and QHP issuers. Many Exchanges rely on the same technology solutions for plan management and other minimum functions of Exchanges in both the individual and small group markets. Aligning the start dates for the employer election period with the start of individual market Exchange open enrollment for 2015 would provide Exchanges with a uniform timeline for improving and launching Exchange services for 2015. Additionally, a uniform QHP filing and review timeline for both markets for 2015 would reduce confusion and provide efficiencies to scale in review, providing potential resource savings to Exchanges and QHP issuers. These efficiencies would still exist even if the SHOP and individual market Exchange were operated by different entities (such where a State has exercised the option at § 155.100(a)(2) to establish and operate only a SHOP, as many QHP issuers seek QHP certification in both markets.

We note that pursuant to § 147.104(b)(1)(i), group coverage purchased in the SHOP between November 15 and December 15 of each year is not subject to employer contribution or group participation rules as defined in § 147.106(b)(3). FF–SHOPs do not enforce minimum participation requirements between November 15 and December 15 of each year, but they are enforced upon initial enrollment outside of this window and at renewal. Aligning the annual employer election period to the start of the individual market Exchange to begin no sooner than November 15, 2014 will provide qualified employers and employees with a period of time to enroll for 2015 coverage when the FF–SHOP minimum participation provisions are not enforced.

We request comments on whether the proposed policy concerning aligning the timing of the SHOP employer election period for 2015 with the individual market annual open enrollment period would pose challenges for State-Based SHOPs as well as comments on any special circumstances that they would face in implementing the proposed policy. If implementing the proposed policy would disrupt the operations of State-Based SHOPs, we request comments on what flexibilities or adjustments to the proposed policy may be necessary to address these concerns.

[37] 2015 Letter to Issuers in the Federally-facilitated Marketplaces (March 14, 2014). Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf*.

For example, a State-based SHOP might have a 2015 small group market QHP certification process under which QHPs for 2015 coverage would be available sooner than November 15, 2014, such that the State-based SHOP's annual employer election period could start earlier than that date.

In §§ 155.725(c)(2) and 155.725(e), we propose to remove the required minimum lengths of both the employer election period and the employee open enrollment period to provide additional flexibility to SHOPs and qualified employers. The existing minimum standards may make it difficult for groups participating in the SHOP to renew coverage in a timely manner, as under the current regulations, the entire process could take as many as 75 days or longer to complete: up to 30 days for the employer's election, 30 days for the employees to enroll, and, depending on when in a given month that enrollment occurs, 15 or more days before coverage becomes effective. Further, this timeframe is not feasible in light of the proposal above to align the earliest date that an employer election period could begin in all SHOPs for plan years beginning in 2015 with the start of open enrollment in the corresponding individual market Exchange for the 2015 benefit year.

This proposal to remove the existing minimum timeframes for qualified employer and qualified employee enrollment decisions will permit SHOPs and qualified employers to act more quickly to renew coverage. Additionally, the existing minimum lengths for the employer election and employee open enrollment periods further complicate the renewal process for qualified employers renewing throughout the calendar year in SHOPs that permit the quarterly update of rates for QHPs. In many States, the updated rate may be published fewer than 45 days prior to the rate taking effect. Therefore, under the existing minimum standard, a qualified employer might not be able to consider the most up-to-date rate information for the coverage it intends to offer. Instead, such rate information might only become available during the employee open enrollment period, in which case the qualified employer may need to reopen either the employer election period or the employee open enrollment period to determine whether the selected QHPs still meet their needs under the new rates. This proposal will ameliorate this concern by permitting SHOPs to complete the entire election and enrollment processes in fewer than 45 days.

We seek comment on all aspects of these proposals.

c. SHOP Employer and Employee Eligibility Appeals Requirements (§ 155.740)

We propose to amend § 155.740(g) by redesignating paragraphs (g)(1) through (g)(3) to more clearly delineate between the requirements associated with valid appeals and those associated with invalid appeals.

In § 155.740(i)(1)(i), we propose to amend the provision by cross-referencing the withdrawal standards proposed in the individual market at § 155.530(a)(1). Under current rules, an appellant who wishes to withdraw his or her appeal request must do so in writing (hard copy or electronic). The amended provision would allow an appellant to withdraw his or her appeal request in writing or by telephone, if the appeals entity is capable of accepting telephonic withdrawals. As noted above in the preamble to § 155.530(a), appeals entities that wish to provide telephonic withdrawals must record, in full, the appellant's statement and telephonic signature made under penalty of perjury and provide a written (in hard copy or electronically) confirmation to the appellant documenting the telephonic interaction. Written confirmation can be captured in the dismissal notice required in the case of a withdrawal under § 155.740(i)(2). Like the proposal in the individual market, this amendment is intended to provide greater efficiency and convenience for an appellant and appeals entity to close an appeal in accordance with the appellant's wishes. We seek comment on this proposal.

8. Subpart O—Quality Reporting Standards for Exchanges

a. Quality Rating System (§ 155.1400)

To implement section 1311(c)(3) of the Affordable Care Act, we propose standards for data collection by QHP issuers and the public reporting by Exchanges of quality rating information. We intend to have a beta testing period in 2015 to provide early feedback to Exchanges and QHP issuers and begin public reporting of quality rating information and enrollee satisfaction survey information in 2016. We believe that it is important that the QRS provide QHP ratings that are based on health care quality, health outcomes, consumer experience, accessibility of care and affordability of care, which is information that is essential to inform consumer choices and to perform certain required functions of an Exchange. As outlined in the November 19, 2013 **Federal Register** Notice with Comment [38] on the QRS framework (QRS Notice), in the initial years, HHS aims to align the measures included in the QRS, to the extent possible, with measures health plans currently report in the commercial markets and public programs. The general functions of an Exchange outlined in 45 CFR 155.200(d) already include a requirement for an Exchange to oversee implementation of quality activities, including the ESS and QRS, and to ensure the reporting of data for these quality activities.

In § 155.1400, we propose that the Exchange must prominently display on its Web site, in accordance with 45 CFR 155.205(b)(1)(v), quality rating information assigned for each QHP under the QRS, as calculated by HHS and in a form and manner specified by HHS, starting in 2016. The standards for QHP issuers regarding the collection and submission of validated quality measures data for the QRS are described in Part 156, Subpart L of this proposed rule. The list of proposed individual quality measures and the proposed organization of the QRS measure sets are described in the QRS Notice. In addition, we intend to release the proposed methodology for calculating quality ratings as well as details regarding measure specifications and data validation processes in technical guidance in 2014.

We believe that the proposed approach where each Exchange displays quality ratings calculated by HHS based on a standard scoring methodology allows for reliable, uniform, and comparable QHP ratings across Exchanges. Therefore, HHS intends to calculate the quality ratings and provide the ratings to Exchanges for prominent display of quality rating information for each QHP offered in the Exchange. We encourage State Exchanges to have a plan review period, similar to what we intend to offer QHP issuers that participate in the Federally-facilitated Exchange, to allow issuers to review their QHPs' quality rating information before the data become public and to identify any discrepancies or errors with the data submitted, as appropriate. We have not incorporated specific criteria for public display by the Exchanges of the QHP quality rating information in proposed § 155.1400. However, we intend to do so in future technical guidance and are considering modeling the display of QHP quality ratings in a consistent manner with existing CMS

[38] Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS) Framework, Measures and Methodology; Notice with Comment, 78 FR 69418 (Nov. 19, 2013).

programs. As outlined in the QRS Notice, we intend to implement a methodology that would assign a quality rating to a QHP using a five star scale. The star ratings would be displayed in a similar style and format to that of Medicare Advantage and Prescription Drug Plan ratings. We believe that the five star quality rating display of Medicare Advantage health plans offers reliable data that is understandable for consumers. HHS anticipates providing the calculated rating information, as proposed in § 155.1400, for display on an Exchange Web site on an annual basis for the open enrollment period. We seek comment on the display of quality ratings of QHPs offered in an Exchange for consumers and employers, which aids comprehension of QHP quality information and which facilitates plan selection.

HHS recognizes that some States already have requirements for and publicly report health plan quality and outcomes data, and we want to encourage State flexibility and innovation, consistent with the Affordable Care Act. In addition to prominently displaying quality rating information for each QHP, as calculated by HHS in accordance with the QRS, a State Exchange may display additional QHP quality-related information, as appropriate, to enhance the consumer experience and help consumers compare QHPs being offered in an Exchange. We believe this proposed approach ensures that standardized information on the quality of health care will be collected and displayed across Exchanges but also provides flexibility for State Exchanges to incorporate additional information on their Web sites to support the plan comparison and selection process by consumers. We also are considering allowing State Exchanges the flexibility to display the QRS rating information, and satisfy the obligation under 45 CFR 155.205(b)(1)(v), by prominently displaying a link to the Federally-facilitated Exchange Web site that would present the Federal quality rating information. We seek comment on this approach including effective ways to display quality rating information to help consumers compare and select QHPs offered in an Exchange.

b. Enrollee Satisfaction Survey System (§ 155.1405)

Similar to the display requirement for the QRS, we propose a display requirement for the Exchange in § 155.1405 relating to the Enrollee Satisfaction Survey (ESS) to implement section 1311(c)(4) of the Affordable Care Act. We propose that the Exchange would prominently display results from the ESS on its Web site, in accordance with § 155.205(b)(1)(iv), as calculated by HHS, and in a form and manner specified by HHS, starting in 2016. The standards for QHP issuers regarding the collection and submission of validated data for the ESS are described in Part 156, Subpart L of this proposed rule. Because we believe that information regarding enrollee experience with the QHP is a fundamental aspect of the overall quality rating, HHS intends to incorporate enrollee experience data from the results of the ESS into the quality rating for each QHP. Research[39] has shown that synthesizing and simplifying health plan quality information presented to consumers eases consumer comprehension; therefore, we have developed a methodology to incorporate enrollee experience data as part of the quality rating information. We intend for the display of quality ratings, including the member experience data from the ESS, to be capable of drilling down to the results for individual quality measures if consumers should choose to access more detail of the data underlying the synthesized global quality rating. We therefore believe that by displaying quality rating information as described in § 155.1400 of this proposed rule (which would incorporate member experience data from the ESS), an Exchange would meet the requirement of displaying ESS information to consumers and employers for the purposes of plan comparison and satisfy the standard outlined in 45 CFR 155.205(b)(1)(iv). HHS anticipates providing results to the full ESS survey to an Exchange on an annual basis. An Exchange may choose to display on its Web site all ESS results, including those scores not used as part of the QRS. We seek comment on this proposed approach for displaying ESS information on an Exchange Web site.

Similar to our approach with the QRS, we also want to encourage State flexibility and innovation, consistent with the Affordable Care Act, with respect to enrollee satisfaction information. We therefore seek comment on whether State Exchanges should have flexibility to display the ESS 2015 beta test results prior to the scheduled public display of the Federal ESS in 2016.[40] Specifically, we solicit feedback on effective ways State Exchanges may share enrollee satisfaction information to help consumers compare and select QHPs offered in an Exchange prior to the availability of the Federal ESS data for the 2017 open enrollment period.

F. Part 156—Health Insurance Issuer Standards Under the Affordable Care Act, Including Standards Related to Exchanges

1. Subpart B—Essential Health Benefits Package

a. Prescription Drug Benefits (§ 156.122)

Section 156.122(c) requires issuers that provide EHB to have procedures in place that allow an enrollee to request and gain access to clinically appropriate drugs not covered by the plan. We are concerned that some enrollees, particularly those with certain complex medical conditions, are having trouble accessing in a timely fashion clinically appropriate prescription drugs, such as prescription drugs that are combination drugs not covered by their plans' formularies. Accordingly, we are considering amending the formulary exceptions standards under § 156.122(c) to require that these processes can be expedited when necessary based on exigent circumstances, such as when an enrollee is suffering from a serious health condition or an enrollee is in a current course of treatment using a non-formulary drug. For example, we could specify that an issuer render decisions regarding formulary exceptions requests within 24 hours following the issuers' receipt of the exceptions requests. This is currently suggested in the 2014 Letter to Issuers.[41] As clarification, the prescription drug standard in § 156.122(a)(1) was not intended to discourage issuers from offering clinically appropriate drugs to enrollees, including combination drugs.

We seek comment on what specific standards would be appropriate for defining this expedited exceptions process, and on all other aspects of this proposal.

[39] Peters EM, Dieckmann N, Dixon A, Hibbard JH, Mertz CK. Less is more in presenting quality information to consumers. Med Care Res Rev. 2007;64 (2):169–90; Hibbard JH, Peters EM. Supporting informed consumer health care decisions: data presentation approaches that facilitate the use of information in choice. Annual Review of Public Health. 2003; 24:413–33.

[40] The standards for QHP issuers regarding the collection and submission of data for the ESS, including the proposed timeline for public reporting of such data, are described below in Part 156, Subpart L of this proposed rule. Also see Agency Information Collection Activities: Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; Notice, 78 FR 65658 (Nov. 1, 2013).

[41] *See* Appendix C of the 2014 Letter to Issuers on Federally-facilitated and State Partnership Exchanges (April 5, 2013). Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.*

b. Cost-Sharing Requirements (§ 156.130)

Under § 156.130(a), cost sharing for 2014 for self-only coverage may not exceed the annual dollar limit described in section 223(c)(2)(A)(ii)(I) of the Code. Under § 156.130(b), for a plan year beginning in calendar year 2014, the annual deductible for a health plan in the small group market for self-only coverage may not exceed $2,000. For 2015 and later years, these limitations are to be increased by an amount equal to the products of these amounts and the premium adjustment percentage established pursuant to paragraph (e) of that section. (The limitations for other than self-only coverage are twice the limitations for self-only coverage.) Under § 156.130(d), any increase in these annual limits that does not result in a multiple of $50 is to be rounded to the next lowest multiple of 50 dollars.

Section 156.130(e) provides that the premium adjustment percentage is the percentage (if any) by which the average per capita premium for health insurance coverage for the preceding calendar year exceeds such average per capita premium for health insurance for 2013, and that this percentage will be published annually in the HHS notice of benefit and payment parameters. The 2015 Payment Notice established our methodology for calculating the premium adjustment percentage.

In calculating the proposed limitations on cost sharing and small group deductible in the proposed 2015 Payment Notice, we rounded these limitations *up* to the next lowest multiple of $50. However, we subsequently learned that the IRS convention for interpreting similar language for a number of longstanding tax parameters—such as indexing methodologies for the alternative minimum tax and the standard deduction—is to round *down* to the nearest applicable multiple. For example, the Department of the Treasury, in a rule on how employers should calculate average annual full-time-equivalent wages for purposes of the small employer health insurance tax credit, provides that if the result is not a multiple of $1,000, employers should round the result to the next lowest multiple of $1,000.[42]

As a result, to align our rounding rules with those used by the Department of the Treasury and the Internal Revenue Service, we propose to amend § 156.130(d) to specify that when indexing the annual limitation on cost sharing and the annual limitation on small group deductibles for years after 2014, we will round to the multiple of 50 dollars that is lower than the number calculated by the formula.

Under this proposed amendment to § 156.130(d), using the premium adjustment percentage of 4.213431463 percent for 2015 we established in the 2015 Payment Notice and the 2014 maximum annual limitation on cost sharing of $6,350 for self-only coverage, which was published by the IRS on May 2, 2013,[43] the 2015 maximum annual limitation on cost sharing would be $6,600 for self-only coverage and $13,200 for other than self-only coverage.

Similarly, under the proposed amendment to § 156.130(d), using the premium adjustment percentage for 2015 of 4.213431463 percent and the 2014 maximum annual limitation on deductibles of $2,000 for self-only coverage, as specified in § 156.130(b)(1)(i), the 2015 maximum annual limitation on deductibles would be $2,050 for self-only coverage and $4,100 for other than self-only coverage.

We seek comment on our proposed amendment and its application for 2015.

2. Subpart C—General Functions of an Exchange

a. QHP Issuer Participation Standards (§ 156.200)

In § 156.200(b)(5), we propose technical amendments to clarify that implementing and reporting for the QRS and implementing a quality improvement strategy are conditions of participation in an Exchange. Specifically, we propose to include a reference to sections 1311(c)(3) and (c)(1)(E) of the Affordable Care Act to correctly align with other quality standards listed as part of QHP certification standards, including the ESS.

We also propose to amend § 156.200 to add paragraph (h) to require that, in order to receive QHP certification, the offering issuer attest that, subsequent to receiving such certification, it will comply with all operational requirements contained in Part 156, Subparts D, E, H, K, L, and M. We are proposing to add paragraph (h), however, to ensure that issuers seeking QHP certification understand and have fully committed to compliance with all operational requirements.

3. Subpart G—Minimum Essential Coverage

a. Other Coverage That Qualifies as Minimum Essential Coverage (§ 156.602)

In the final rule published on July 1, 2013 (78 FR 39494), we designated certain types of coverage as minimum essential coverage, including self-funded student health coverage (for plan or policy years beginning on or before December 31, 2014), Refugee Medical Assistance supported by the Administration for Children and Families, Medicare advantage plans, State-high risk pool coverage (for plan or policy years beginning on or before December 31, 2014) and other coverage that qualifies pursuant to the minimum essential coverage application process in 45 CFR 156.604. We also established a process by which sponsors of other coverage not designated as minimum essential coverage could apply with HHS to be recognized as minimum essential coverage.

In guidance published on October 31, 2013, we further indicated that coverage under a group health plan provided through insurance regulated by a foreign government (and not regulated by a State) is recognized as minimum essential coverage for a month with respect to an individual who, for such month, is physically absent from the United States for at least one day of the month. In addition, coverage under a group health plan provided through insurance regulated by a foreign government (and not regulated by a State) will also be recognized as minimum essential coverage with respect to an individual who is physically present in the United States for an entire month if the coverage provides health benefits within the United States while the individual is an expatriate.[44] The rationale behind this policy was that insurance that is regulated by a foreign government and not subject to regulation by a State does not meet the definition of health insurance coverage under the PHS Act, and thus should not be considered for purposes of a PHS Act analysis. The effect of this policy is to place group health coverage provided through foreign insurance on the same footing as self-insured group health coverage with respect to being deemed minimal

[42] *See* 26 CFR 1.45R–2(f)(1).

[43] See *http://www.irs.gov/pub/irs-drop/rp-13-25.pdf.*

[44] *See* CCIIO Sub-Regulatory Guidance: Process for Obtaining Recognition as Minimum Essential Coverage (October 31, 2013. Available at: *http://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/mec-guidance-10-31-2013.pdf.*

essential coverage without having to go through the application process.

We now propose to add new paragraph (e) to § 156.602 codifying the treatment of foreign group health coverage as stated in the October 31, 2013 guidance. We propose to designate foreign group health coverage for expatriates as minimum essential coverage if the coverage is self-insured, or is insured by an entity that is not subject to regulation by a State. Specifically, we propose to clarify in the regulations that foreign group health coverage is group health coverage that (1) is not insured by an issuer regulated by a State and (2) is for expatriates who are citizens or nationals of the United States residing abroad, or is for expatriates who are not citizens or nationals of the United States residing in the United States. We propose that if coverage for expatriates who are citizens or nationals of the United States who reside abroad is provided by a self-insured group health plan, or is provided by group health insurance not regulated by a State or group health coverage provided by a foreign national health plan, the coverage is designated as minimum essential coverage for any month that the citizen or national of the United States is physically absent from the United States for at least one day of the month.

For purposes of this section, we propose to define an ''expatriate'' as an individual for whom there is a good faith expectation that such individual will reside outside of their home country for at least six months of a 12-month period, including any covered dependents. This definition was adopted from the January 9, 2014 Affordable Care Act Implementation FAQs.[45] Another option is that we define ''expatriate'' more broadly to apply to individuals that are living outside of their home country for less than six months. For example, the Black's Law Dictionary defines ''expatriate'' as a citizen of country A living in country B where the classification of this citizen occurs regardless of if the citizen has a short stay or an extended or lifetime stay in country B.[46] We solicit comments on either definition of expatriate discussed above or another definition that would be appropriate for this section.

If an expatriate is a citizen or national of the United States and is physically present in the United States for an entire month, we propose that their foreign group health coverage is designated as minimum essential coverage if the coverage provides health benefits within the United States, and is provided by a self-insured group health plan, group health insurance regulated by a foreign government (and not by a State), or group health coverage provided by a foreign national health plan. We propose this time period so that expatriates who are citizens or nationals of the United States working abroad may visit the United States for a short period of time without their foreign group health coverage losing its designation as minimum essential coverage. We propose that the coverage must provide health benefits within the United States to ensure that the coverage is not limited to providing health benefits while an individual is absent from the United States. We solicit comments on the time period that expatriates who are citizens or nationals of the United States working abroad can remain in the United States without their foreign group health coverage losing its designation as minimum essential coverage.

In 45 CFR 156.602(e), we propose that if the foreign group health coverage is for expatriates residing in the United States who are not citizens or nationals of the United States, the coverage is designated as minimum essential coverage if the coverage provides health benefits within the United States, and is provided by a self-insured group health plan, group health insurance regulated by a foreign government (and not regulated by a State), or group health coverage provided by a foreign national health plan. We propose that the coverage must provide health benefits within the United States so as to ensure that the coverage provides health insurance benefits in the United States while an individual is living in the United States.

To ensure that expatriates enrolled in foreign group health coverage are aware that their coverage has been designated as minimum essential coverage and that foreign group health coverage complies with the same reporting requirements as other types of minimum essential coverage, we propose to require that the sponsor, issuer, or plan administrator, as applicable, of any foreign group health coverage must provide notice to enrollees who are citizens or nationals of the United States of its minimum essential coverage status and comply with the information and reporting requirements of section 6055 of the Code and implementing regulations with respect to those enrollees. We welcome comments on any aspect of these proposals.

b. Requirements for Recognition as Minimum Essential Coverage for Types of Coverage Not Otherwise Designated Minimum Essential Coverage in the Statute or This Subpart (§ 156.604)

Section 45 CFR 156.604 outlined a process by which types of coverage not statutorily specified and not designated by regulation as minimum essential coverage may seek to be recognized as minimum essential coverage. We established the requirement that the application must be submitted to HHS on behalf of the plan or policy by the sponsor of the coverage or government agency.

We now propose to clarify that the application may also be submitted to HHS on behalf of the plan or policy by a health insurance issuer or a plan administrator because the health insurance issuer or plan administrator may be the more appropriate party to submit the application. For example, a health insurance issuer may more efficiently provide the information required for an application on behalf of a foreign health insurance plan sold in the individual market to expatriates living abroad. We welcome comments on all aspects of these proposals.

4. Subpart I—Enforcement Remedies in Federally-Facilitated Exchanges

a. Available Remedies; Scope (§ 156.800)

In subpart I of 45 CFR part 156, finalized on August 30, 2013 in the rule Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals (Program Integrity Rule),[47] we established the enforcement remedies available to HHS for enforcing standards applicable to issuers offering QHPs in the FFEs. Since the publication of that rule and in the course of our routine monitoring of QHP issuers for compliance with applicable FFE standards, we have received multiple inquiries from QHP issuers and States about whether HHS will be coordinating and sharing information about QHP issuers with State regulatory entities as part of its oversight activities. We propose adding paragraph (d) to clarify that HHS may consult and share information about QHP issuers with other Federal and State regulatory and enforcement entities to the extent that

[45] *See* FAQs about Affordable Care Act Implementation (Part XVIII) and Mental Health Parity Implementation (January 9, 2014). Available at: *http://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/aca_implementation_faqs18.html* and *http://www.dol.gov/ebsa/faqs/faq-aca18.html*.

[46] *See* Black's Law Dictionary Free (2d ed. 2014). Available at: *http://thelawdictionary.org/expatriate*.

[47] Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals, 78 FR 54070 (August 30, 2013) (to be codified at 45 CFR parts 147, 153, 155, and 156).

this information is necessary for HHS to determine whether an enforcement remedy under subpart I is appropriate. We believe this is consistent with our intent to coordinate with States in enforcement actions as described in the proposed Program Integrity Rule.[48]

b. Bases and Process for Imposing Civil Money Penalties in Federally-Facilitated Exchanges (§ 156.805)

In the Program Integrity Rules, we established the bases for HHS to impose CMPs against QHP issuers for violations of certain standards applicable to issuers offering QHPs in the FFEs. In § 156.805(d) we set forth the general process for notifying the QHP issuer against which the CMP is being imposed. The general process did not address how prior to the imposition of the CMP, the QHP issuer would be notified of the alleged violation which forms the basis for the imposition of CMP. We propose adding § 156.806 to explain that HHS will provide a written notice to the issuer, to include a description of the potential violation, a 30-day period for the QHP issuer to respond and to provide additional information to refute an alleged violation.

If HHS determines that a CMP will be imposed, HHS will notify the QHP issuer as required under § 156.805(d). We note that § 156.805(d) does not specify the method of delivery of such notice. We believe it is important to ensure that such notices are appropriately delivered to the QHP issuer to provide the QHP issuer with proper notice. We propose adding § 156.805(d)(3) to require that delivery of the notice required in paragraph (d) will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. This requirement is identical to the requirement under § 158.613 which applies to the delivery of notice of civil penalties under 45 CFR Part 158, with which we believe QHP issuers will generally be familiar. We believe this proposed requirement will ensure that QHP issuers have proper notice of HHS's intent to impose CMPs. Finally, we also note that paragraph (e)(2) requires HHS to notify the QHP issuer of any penalty that has been assessed and of the means by which the responsible entity may satisfy the judgment. We propose rewording the regulatory text to clarify that the responsible entity refers to the QHP issuer against whom a CMP is being imposed or another entity responsible for satisfying the CMP assessment and that the judgment refers to the CMP assessed under of this subpart.

c. Bases and Process for Decertification of a QHP Offered by an Issuer Through a Federally-Facilitated Exchange (§ 156.810)

In subpart I of 45 CFR part 156, finalized in the Program Integrity Rule, we established the bases for HHS to decertify QHPs for violations of certain standards applicable to issuers offering QHPs in the Federally-facilitated Exchanges. Under § 156.810(a) we set forth the bases for decertification. Since the publication of this final rule, we believe that certain paragraphs should be clarified. For example, paragraph (a)(6) should be reworded to clarify that the certification criteria means the standards under subpart C of this part. In paragraph (a)(9), it was unclear which laws were intended and we proposing clarifying that violation of State or Federal law relating to internal claims and appeals and external review processes are bases for decertification under this paragraph. We propose aligning the standards set forth under subparts K and M with the bases for decertification. We propose adding a paragraph (12) to reflect that HHS may decertify a QHP if the QHP issuer substantially fails to meet the requirements related to the cases forwarded to QHP issuers under Subpart K, and adding a paragraph (13) to reflect that HHS may decertify a QHP if the QHP issuer substantially fails to meet the requirements in Subpart M. Finally, in the preamble to the proposed Program Integrity Rule, we explained that when the basis for a decertification is one in which the QHP enrollees' ability to access necessary medical items or services is at risk or the integrity of an FFE is substantially compromised, HHS would have the authority to pursue an expedited decertification (78 FR 37062). Because QHP issuers are required to demonstrate compliance with the minimum certification standards in subpart C of part 156 and Exchanges are required under section 155.1010(a)(2) to monitor QHP issuers for demonstration of ongoing compliance with the certification requirements, we believe that it is appropriate for the FFEs to be able to pursue an expedited decertification when HHS has determined that the QHP no longer meets applicable certification standards. Accordingly, we propose amending § 156.810(d) to reflect this change.

5. Subpart L—Quality Standards

a. Establishment of Standards for HHS-Approved Enrollee Satisfaction Survey Vendors for Use by QHP Issuers in Exchanges (§ 156.1105)

In the rule Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014 (Second Program Integrity Rule)[49] at 45 CFR 156.1105, we established processes for HHS to approve and oversee ESS vendors that will administer the ESS on behalf of QHP issuers. We outlined a process by which enrollee satisfaction survey vendors would submit an annual application demonstrating that they meet all of the application and approval standards in paragraphs (a) and (b). Lastly, we noted that HHS would publish a list of approved enrollee satisfaction survey vendors on an HHS Web site.

We propose to amend § 156.1105 to also include monitoring and appeals processes that would apply for plan years beginning 2015. In paragraph (d), we propose that HHS will monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the application and approval standards. Further, we propose that if HHS determines that an approved vendor is non-compliant with the standards outlined in paragraph (b), they may be removed from the approved list described in paragraph (c) and/or the submitted survey results may be ineligible to be included for ESS results.

We propose to establish a monitoring process to prepare for situations when an HHS-approved enrollee satisfaction survey vendor is no longer in compliance with the standards outlined in § 156.1105. It is possible that once the enrollee satisfaction survey vendor is approved and contracts with a QHP issuer to provide survey administration services, the HHS-approved vendor may stop participating in or complying with required activities described in paragraph (b)(1) (for example, the vendor does not participate in site visits or conferences calls or fails to become a registered user for the ESS data warehouse). We propose that in the event that HHS determines, through its oversight activities, that the HHS-approved survey vendor is non-compliant, a process would already be

[48] Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, Premium Stabilization Programs, and Market Standards; Proposed Rule, 78 FR 37032 (June 19, 2013).

[49] Patient Protection and Affordable Care Act; Program Integrity: Exchange, Premium Stabilization Programs, and Market Standards; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 FR 65046 (Oct. 30, 2013) (to be codified at 45 CFR parts 144, 146, 147, 153, 155, and 156).

in place to take appropriate remedial action as well as notify QHP issuers and the public of any changes to the approved list of vendors. We propose that, in addition to other existing remedies, HHS would have the ability to remove a survey vendor from the approved list and/or determine that the submitted survey results are ineligible to be included for ESS results, as the validity of the results may be impacted. HHS would also update the published list of approved vendors to reflect any changes. We seek comment to inform future guidance on the factors that should be considered, as well as the conditions that may lead to the removal of an approved survey vendor from the HHS approved list and/or a determination that the submitted survey results are ineligible to be included for ESS results.

In paragraph (e), we propose an appeals process for an ESS vendor that submits an application to HHS for approval, as described in paragraph (a), and is not approved. Specifically, we propose that an enrollee satisfaction survey vendor may appeal HHS's decision by notifying HHS in writing within 15 days of the notification of not being approved by HHS and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b). HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation. An enrollee satisfaction survey vendor that becomes approved via the appeals process would be included in the approved list, described in paragraph (c). We seek comment on the proposed approach to implementing an appeals process for survey vendors that are not approved by HHS after submission of an application for approval.

b. Quality Rating System (§ 156.1120)

In addition to proposing standards for Exchanges to oversee the QRS and display quality rating information on Exchange Web sites as set forth in § 155.1400 of this proposed rule, we also propose standards for QHP issuers to collect and report the necessary information to implement the QRS pursuant to section 1311(c)(3) of the Affordable Care Act. While the QRS Notice describes areas such as the overarching goals, framework, measure selection process and individual measures of the QRS, this proposed rule outlines the QRS implementation and reporting standards for QHP issuers.

In the QRS Notice, we proposed a QRS measure set that applies to QHPs that provide family and adult self-only coverage and we proposed a separate Child-only QRS measure set applying to QHPs that provide child-only coverage. CMS continues to monitor the number of child-only QHP offerings on the Exchanges. A limited number of child-only QHPs and enrollees may prohibit reliable child-only QHP rating calculations. As mentioned in the QRS Notice, we will also consider the development of a quality rating system applicable to other Exchange offerings, such as stand-alone dental plans, catastrophic plans, and health savings accounts. After considering public comment as well as the review by the Measures Application Partnership's Health Insurance Exchange Taskforce convened by the National Quality Forum, we intend to finalize the quality measures outlined in the QRS Notice and provide measure specifications in future technical guidance. Our goal is to publish this future technical guidance on a HHS Web site in 2014 to provide time for QHP issuers to collect and submit the relevant validated data for the 2015 beta test.

QRS Implementation and Reporting

At § 156.1120(a), we propose data submission requirements for a QHP issuer for the information necessary to calculate the quality ratings under the QRS, and in § 156.1120(b), we propose to direct a QHP issuer to annually submit data necessary to calculate the QHP's quality ratings to HHS and the Exchange, on a timeline and in a standardized form and manner specified by HHS. In paragraph (a)(1), we propose that a QHP issuer must submit data to calculate quality ratings for each QHP that has been offered in an Exchange for at least one year. HHS proposes to phase in implementation of the QRS over time in recognition of the fact that QHP issuers would need time to collect, ensure the reliability of, and report quality measure data. In addition, certain quality measures require one or two year reference periods, and QHP issuers would need time for data collection, validation and submission. Therefore, we propose that for the first year that a QHP is offered in an Exchange, the QHP issuer would prepare to submit the required validated data elements for QRS beta testing in the second year that the QHP is offered in an Exchange. The QHP issuer would then submit the required validated data elements for QRS public reporting in the third year that the QHP offers coverage (reflecting second year data). For example, an issuer that offers a QHP in the Exchange during the 2013 open enrollment period for coverage beginning in January 2014 would submit the required validated data for a QRS beta testing period beginning in mid-2015 (coverage year two), which would not be publicly reported by the Federally-facilitated Exchange. The issuer would next be required to submit the required validated data for the QHP offered in the Exchange to calculate quality rating information for QRS public reporting during the 2016 open enrollment period for the 2017 coverage year (coverage year four). Specifically, we intend for the QRS data reporting period to begin the first month of a calendar year through the middle of the sixth month of the calendar year. For example, a QHP issuer submitting data for the 2015 QRS beta testing period would submit data on or around June 15, 2015 and would submit data for its first QRS public reporting on or around June 15, 2016. We intend for the QRS to include data from all eligible QHP enrollees covered during the measurement year which would be the previous calendar year(s) and based on measure specifications for that year's collection. We intend to provide details of the QRS rating methodology, measure specifications, criteria for quality rating display, and information regarding QRS data validation in technical guidance that would be periodically updated.

In paragraph (a)(2), we propose to direct a QHP issuer to submit data that has been validated in a form and manner specified by HHS. We believe that the submission of validated data by QHP issuers is necessary to ensure the integrity and reliability of the QRS to allow consumers objective and meaningful comparisons of the QHPs' quality data. We believe that review of quality measures data by an independent third party entity will ensure that only valid and appropriate data are used to calculate the quality rating information for QRS public reporting. In the initial years, HHS intends to direct QHP issuers to follow the process specified by the quality measure steward for validation of its quality measures that are incorporated into the QRS. For example, for any Healthcare Effectiveness Data and Information Set (HEDIS)® measure in the QRS, the measure should be validated through the HEDIS® Compliance Audit process using a certified auditor, as defined by the National Committee for Quality Assurance (NCQA). We have drawn from our experience with the Medicare program which also ensures that clinical quality HEDIS® data submitted and reported on behalf of the Medicare Advantage and Prescription Drug Programs are valid and reliable by

requiring data to be validated through the NCQA HEDIS® Compliance Audit process before being provided to CMS for public reporting. HHS would specify in technical guidance a validation process for any measures for which the measure steward has not defined a validation process. In the future and as the QRS evolves, HHS is considering establishing an application and approval process for independent third party data validators to allow QHP issuers to contract with validators that would be approved and monitored by HHS.

In paragraph (a)(3), we propose that a QHP issuer must include information in its data submission only for those QHP enrollees at the reporting level specified by HHS that is necessary to calculate the quality ratings. As we stated in the QRS Notice, HHS intends to specify that for the initial years of QRS implementation, a QHP issuer must collect and submit data for enrollees in each product type offered by a QHP issuer in each State for which the QHP operates (for example, Health Maintenance Organization (HMO), Point of Service (POS), and Preferred Provider Organization (PPO)).[50] While we understand that there may be value in reporting quality rating information at more granular QHP levels, such as the QHP product metal level, we believe that a QHP's enrollment size at the product metal level will be too small to ensure reliable QRS results across the measure domains in the beginning years of the Exchange. We intend to revisit the level of QHP issuer reporting for the QRS as Exchanges mature and enrollment sizes increase. We also recognize that a QHP issuer may offer a QHP outside an Exchange that would be considered the same plan as one that is certified as a QHP and offered through the Exchange, if the benefits package, provider network, service areas and cost-sharing structure of the two offerings are identical as outlined in the Program Integrity Final Rule.[51] We intend to allow a QHP issuer to collect data for the QRS based on enrollees of QHPs offered through and outside of the Exchange as long as they are considered the same plan. If this approach is finalized, we intend to clarify the operational details of this approach in future technical guidance.

We seek comment on the data submission requirements proposed in paragraph (a) including comment regarding the reporting timeframes and any additional criteria for the submission or reporting of quality data for QRS purposes. We seek comment on the proposed approach, for the initial years of QRS implementation, of product level reporting and allowing the incorporation of quality measure data from QHPs offered outside the Exchange, if they are considered the same plan as the QHP offered through the Exchange. We also solicit comment to inform future rulemaking regarding the potential requirement for QHP issuers to use independent third party data validators that would be approved and monitored by HHS for QRS purposes.

As described in 45 CFR 156.275, QHP issuers are required to be accredited on the basis of local performance of a QHP by an accreditation entity recognized by HHS, and to submit to such entity clinical quality measures, such as HEDIS®. We are seeking comment to inform future rulemaking on how best to align QRS measures reporting requirements with the accreditation standards for QHP issuers.

We note that multi-State plans, as defined in § 155.1000(a), are subject to reporting QRS data for calculation of quality ratings by HHS, as described in paragraph (a). The U.S. Office of Personnel Management (OPM) will provide guidance on quality reporting to issuers with whom it holds multi-State plan contracts.

Marketing Materials

In paragraph (c), we propose that an issuer may reference its QHP's quality rating information in its marketing materials, in a manner specified by HHS. In the subsequent section 156.1125 regarding the ESS, we propose a similar marketing standard in § 156.1125(c) that a QHP issuer may reference the ESS results for its QHPs in its marketing materials, in a manner specified by HHS.

A QHP issuer has the option to use quality rating information and ESS results in its marketing materials; however, an issuer that elects to use the information must do so in a manner that does not mislead consumers into enrolling in a QHP based on inaccurate information. We intend to provide details regarding display of rating information and ESS results in marketing materials in technical guidance that we anticipate releasing in 2015. We seek comment regarding the proposed allowance for issuers to include its QHPs' quality rating information and ESS results in its marketing materials in paragraphs (c) of 156.1120 and 156.1125 and ways to prevent the use of the information in a misleading manner when being presented to consumers.

c. Enrollee Satisfaction Survey (§ 156.1125)

Section 1311(c)(4) of the Affordable Care Act directs the Secretary to establish an enrollee satisfaction survey (ESS) system that would evaluate the level of enrollee satisfaction of members in each QHP with more than 500 enrollees in the previous year that is offered through an Exchange. It also directs Exchanges to display enrollee satisfaction information on their Web sites to allow individuals to readily compare enrollee satisfaction data between QHPs. To implement this provision, HHS is developing the ESS as described in the **Federal Register** Notice dated Nov. 1, 2013 (ESS Notice).[52] We outline standards in this proposed rule for a QHP issuer to collect and submit validated enrollee experience data from QHPs offered through an Exchange.

We believe it is important that QHPs offered through Exchanges be assessed using a reliable and valid survey, administered and scored according to standards developed and monitored by independent organizations. We based the ESS on the Consumer Assessment of Health Providers and Systems (CAHPS®) Health Plan 5.0 Medicaid survey to assure consumers and stakeholders that the ESS survey data submitted meet the validity and reliability standards reported by the CAHPS® program and are comparable to data from other quality comparison tools. We used existing CAHPS® supplemental item sets or other CAHPS® surveys, when available and appropriate, to identify any additional items for the ESS.

ESS Administration

At § 156.1125(a), we propose to direct QHP issuers to contract with an HHS-approved ESS vendor, as identified by § 156.1105, to administer the ESS of the QHP's enrollees. We also propose to direct a QHP issuer to authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf. We believe this proposed approach aligns with the Medicare program, which uses a similar process by having approved survey vendors administer the CAHPS® survey

[50] Patient Protection and Affordable Care Act; Exchanges and Qualified Health Plans, Quality Rating System (QRS) Framework, Measures and Methodology; Notice with Comment, 78 FR 69418 (Nov. 19, 2013).

[51] Patient Protection and Affordable Care Act; Program Integrity: Exchange, SHOP, and Eligibility Appeals; Final rule, 78 FR 54070 (Aug 30, 2013).

[52] Agency Information Collection Activities: Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; Notice, 78 FR 65658 (Nov. 1, 2013).

to an issuer's Medicare Advantage and Prescription Drug Program enrollees. Similar to the proposed general requirement for the QRS in § 156.1120(a), which directs a QHP issuer to submit data to HHS and the Exchange, QHPs must ensure that their contracted ESS vendors submit the data collected from the ESS survey to HHS and the Exchange so that HHS can calculate the ESS scores and benchmarks based on a standard scoring methodology that will allow for reliable, uniform, and comparable scoring across Exchanges. HHS intends to send calculated ESS scores to the Exchanges for their respective QHPs and also intends to use a subset of scores from the ESS as part of the quality rating for QHPs as described in § 156.1120. We intend for the ESS to be administered from January through April of each calendar year beginning in 2015.

HHS is considering the development of an ESS child-only survey to assess the experience of children enrolled in child-only plans. Similar to the implementation of the QRS child-only measure set, CMS is currently assessing the feasibility of a child-only ESS based upon the number of child-only QHPs and enrollees in Exchanges.

In paragraph (b), we propose several data requirements to clarify the standards for collection and submission of ESS data. At § 156.1125(b)(1), we propose to direct a QHP issuer to collect data of eligible enrollees for each QHP with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year following a survey sampling methodology provided by HHS. We propose that eligible enrollees would be those individuals enrolled for at least six months during the year prior to the administration of the survey and solicit comment on this approach.

In paragraph (b)(2), we propose to direct a QHP issuer to submit data, necessary to conduct the ESS, that has been validated in a form and manner specified by HHS. We propose that the data for the sample of eligible enrollees that a QHP issuer provides to their contracted ESS vendor be validated in a consistent way as data validated for the QRS. For example, if a QHP issuer submits data collected for a quality measure that is validated through the HEDIS® Compliance Audit process using a NCQA certified auditor, we expect the data that the QHP issuer provides to its HHS-approved ESS vendor for the ESS sample be included in that validation process. We solicit comment on this approach for validation of the data for the ESS sample of eligible enrollees.

In paragraph (b)(3), we propose to direct a QHP issuer to include only those QHP enrollees at the reporting level specified by HHS, for data submitted for the ESS. We believe that the QHP metal level (i.e., HMO Silver, HMO Bronze, PPO Silver, PPO Bronze) for each of the issuer's products is the appropriate level (if enrollment is sufficient to ensure credibility) to assess enrollee experience and would provide information regarding experience with plans charging differing premiums. We intend to aggregate the ESS data from the QHP metal level to the QHP product level (for example, a QHP issuer's HMO silver and HMO bronze would be aggregated into one HMO level score) for public reporting purposes to provide consistency with the product-level data that would be submitted for the QRS and align with the QRS methodology in the initial years of implementation of these proposed quality standards for QHPs.

We recognize that a QHP issuer may offer a plan outside an Exchange that would be considered the same plan as one that is certified as a QHP and offered through the Exchange, as defined in § 153.500. Similar to our proposed approach with the QRS, we are considering in the initial years to allow a QHP issuer to include enrollees of QHPs offered through and outside of the Exchange, to ensure a reliable ESS sample size, as long as they are considered the same plan as established in § 153.500. We intend to clarify the operational details of this approach in future technical guidance. OPM will issue technical guidance regarding the sampling methodology for multi-State plans, as defined in 45 CFR 155.1000(a). We envision that the sampling methodology for multi-State plans will align with that of QHPs.

In paragraph (d), we propose to direct a QHP issuer to submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a form and manner specified by HHS. We intend to align the timeframes of the proposed reporting requirements for the ESS and the QRS. In future technical guidance, we also intend to specify the timeframes for a QHP issuer to submit the sampling data to its contracted ESS vendor and for the vendor to submit to HHS and the Exchange, data from the administration of the survey.

ESS Implementation and Reporting

HHS proposes to phase in implementation of the ESS over time which is consistent with the proposed implementation of the QRS. We believe this will allow for appropriate development and testing of the ESS and the survey methodology; time for QHP issuers to prepare for data collection, validation and submission; and time for QHP enrollees to build experience with the QHP and their providers to adequately assess their experience and to ensure reliable survey results. Therefore, we propose that for QHPs offered in the Exchange during the 2014 open enrollment period, the QHP issuer would submit the required data elements for ESS beta testing in 2015. The QHP Issuer would then submit the required data elements in 2016 for ESS public reporting during the 2017 open enrollment period. Specifically, we intend for QHP issuers to provide data necessary to conduct the survey to their contracted HHS-approved ESS vendors, as described in paragraph (a), during the first month of the calendar year and to ensure that survey results are submitted to HHS or its' designee, by the fifth month of the calendar year. For example, a QHP issuer reporting data for the 2015 ESS beta test would provide sample frame data necessary to conduct the ESS for eligible enrollees who would be surveyed, to their contracted survey vendor in January 2015, allowing adequate time for the vendor to draw the sample in time to begin fielding the survey on February 1. Then, a QHP issuer would ensure that the ESS survey results are submitted to HHS on or around May 31, 2015. For the first year of ESS public reporting, a QHP issuer would provide sample frame data necessary to conduct the ESS in January 2016 and ensure that results are submitted to HHS or its' designee on or around May 31, 2016. We intend for the ESS sample to include all eligible QHP enrollees covered during the measurement year which would be the previous calendar year and based on sampling specifications. We intend to provide details of the ESS sampling methodology in technical guidance that would be periodically updated and which will be published in draft form on an HHS Web site to obtain feedback from stakeholders.

We seek comment on the proposed requirement in paragraph (a) to direct a QHP issuer to contract with an HHS-approved enrollee satisfaction survey vendor and to authorize its contracted vendor to submit data to HHS and the Exchange. Specifically, request feedback on our proposed approaches for data collection from eligible enrollees for each QHP with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year, to require validation consistent with the process for QRS measure data and to provide data for eligible enrollees

at the QHP metal level for each of the issuer's products offered on the Exchange. We also seek comment on the proposed annual data submission requirements in paragraph (b) and (d).

We note that Multi-State Plans, as defined in 45 CFR 155.1000(a), are subject to providing the data described in paragraph (b). The OPM will provide guidance on ESS reporting to issuers with whom it holds Multi-State Plan contracts.

Marketplace Survey

Sections 1313 and 1321(a) of the Affordable Care Act provide the Secretary with general authority to establish standards and regulations related to Exchanges, QHPs, and other components of title I of the Affordable Care Act. In § 155.1200(b)(3), we direct State Exchanges to submit performance monitoring data on an annual basis, which would include information on consumer satisfaction. Pursuant to this legal authority, HHS has proposed a consumer experience survey, or the Marketplace survey, to assess consumer experience with the Exchange.[53] Similar to the ESS, the Marketplace survey has been developed based on the core set of CAHPS® principles and the format and language of the survey drew from existing CAHPS® items, to the extent possible. However since the CAHPS® program does not have a comparable survey to assess entities similar to Exchanges, the Marketplace survey items are new and were developed based on research and feedback from public comment, technical experts and focus groups. We believe it is important to assess experience of consumers interacting with an Exchange including obtaining information regarding aspects such as the application and eligibility determination process for Medicaid/Children's Health Insurance Program (CHIP) coverage and the Insurance Affordability Programs. We anticipate that results from the Marketplace survey would drive quality improvement in Exchanges and provide regulators and stakeholders with information to use for monitoring and oversight purposes.

We intend to use a single contracted survey vendor to administer the annual Marketplace survey for each Exchange. We are currently in the survey developmental testing period for the Marketplace survey in the States in the Federally-facilitated Exchange and we anticipate the survey beta test to be conducted in early 2015 in all States. We intend to provide each Exchange with its respective Marketplace survey results, beginning in 2015, to be able to make improvements for upcoming open enrollment periods.

We seek further comment to inform future rulemaking regarding data provided by State Exchanges to conduct the Marketplace survey. We are considering directing a State Exchange to provide sampling data for four types of consumers in an Exchange including: (1) Potential applicants (individuals who provided contact information but did not submit an application); (2) potential enrollees (individuals who successfully applied and were given eligibility and plan information but did not enroll); (3) enrollees (individuals successfully enrolled); and (4) effectuated enrollees (individuals who have made their first premium payment). We are also considering directing a State Exchange to submit sampling data for the Marketplace survey based on language preference and disability status across each Exchange and we seek comment on the feasibility for a State Exchange to provide such data.

G. Part 158—Issuer Use of Premium Revenue: Reporting and Rebate Requirements

1. Subpart A—Disclosure and Reporting

a. ICD–10 Conversion Expenses (§ 158.150)

In September 2012, the Secretary changed the date on which issuers are required to adopt ICD–10 as the standard medical code set from October 1, 2013 to October 1, 2014. Because HHS cannot accept claims using the ICD–10 code sets prior to that date, issuers may incur conversion costs in 2014 that would otherwise have been incurred only in 2012 and 2013. In the 2012 and 2013 MLR reporting years, issuers were allowed to report their ICD–10 conversion costs as expenditures for activities that improve health care quality (QIA), up to 0.3 percent of an issuer's earned premium in the relevant State and market (MLR Final Rule, 76 FR 76574). Because the ICD–10 implementation date has been postponed to 2014, we propose that issuers be allowed to report their 2014 ICD–10 conversion costs as QIA in the 2014 reporting year, up to 0.3 percent of an issuer's earned premium in the relevant State and market. Although there are no plans to further postpone the ICD–10 implementation date, in recognition of this possibility and to avoid the need for additional regulatory changes, the regulatory change proposed herein permits issuers to include their ICD–10 conversion costs as QIA through the MLR reporting year in which ICD–10 implementation is required by the Secretary.

2. Subpart B—Calculating and Providing the Rebate

a. MLR and Rebate Calculations in States With Merged Individual and Small Group Markets (§§ 158.211, 158.220, 158.231)

Our previous rulemakings concerning PHS Act section 2718 permitted issuers to aggregate individual and small group market data for MLR purposes in States that require these two markets to be merged pursuant to section 1312(c)(3) of the Affordable Care Act. This proposed rule would modify the requirements for data aggregation in § 158.220(a) and § 158.231(a) to specify that the individual and small group market data must always be aggregated if a State requires these two markets to be merged. In addition, this proposed rule would modify the requirements regarding a higher State MLR standard in § 158.211 to clarify that if a State establishes a higher MLR standard for the merged market, this higher standard must be used to calculate any rebates for the merged market. These modifications would align the MLR methodology in the Federal MLR rule with the MLR methodologies applied by the affected States.

b. Accounting for Special Circumstances (§ 158.221)

On November 14, 2013, the Federal government announced a policy under which, if certain conditions were met, it would decline to enforce certain specified 2014 market reforms against certain non-grandfathered health insurance coverage in the individual or small group market renewed between January 1, 2014 and October 1, 2014, and requested that States adopt a similar non-enforcement policy.[54] CMS noted in the Proposed 2015 Payment Notice (78 FR 72322) that this transitional policy would not have been anticipated by issuers in setting rates for 2014 and stated that we were exploring modifications to different programs to help mitigate the impact of this policy.

Issuers that provided transitional coverage may have incurred additional administrative costs, such as expenses related to developing and sending required consumers notices, and creating and submitting new policy and

[53] Agency Information Collection Activities: Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection; Notice, 78 FR 65658 (Nov. 1, 2013).

[54] Letter to Insurance Commissioners, Center for Consumer Information and Insurance Oversight, November 14, 2013. *Available at: http://www.cms.gov/CCIIO/Resources/Letters/Downloads/commissioner-letter-11-14-2013.pdf.*

rate filings. We also recognize that issuers of QHPs in the individual and small group markets may have incurred costs due to technical problems during the launch of the State and Federal Exchanges.

Pursuant to the direction under PHS Act 2718(c), our development of the standardized methodologies for calculating an issuer's MLR must be designed to ''take into account the special circumstances of smaller plans, different types of plans, and newer plans.'' In the MLR Interim Final Rule (75 FR 74864), HHS exercised this authority by making adjustments to the formula for calculating an issuer's MLR with respect to ''expatriate plans'' (i.e., policies that provide coverage to employees outside their country of citizenship, employees outside their country of citizenship and outside their employer's country of domicile, and non-U.S. citizens working in their home country) and ''mini-med'' plans (i.e., plans with a total annual benefit maximum of $250,000 or less).

In its discussion of the ''special circumstances'' that applied to expatriate plans, the Interim Final Rule noted that ''their unique nature results in a higher percentage of administrative costs in relation to premiums than plans that provide coverage primarily within the United States.'' [55] Examples of the higher administrative costs for these plans include: Identifying and credentialing providers worldwide in countries with different licensing and other requirements from those found in the United States, processing claims submitted in various languages that follow various billing procedures and standards, providing translation and other services to enrollees, and helping subscribers locate qualified providers in different countries. The Interim Final Rule also recognized the ''special circumstances'' that applied to mini-med plans. In this latter case, it was not higher administrative costs, but lower claims costs relative to administrative costs, due to the very low annual dollar limits of mini-med plans. In both cases, adjustments were made to the MLR methodology as applied to such plans so that they would not be required to pay rebates based on their plan design, even if they were relatively as efficient as other plans that are able to meet the MLR standard under the standard methodology.

Consistent with this approach, we are proposing to exercise our authority to account for the special circumstances of plans affected by the transitional policy or the technical problems during the launch of the State and Federal Exchanges. These adjustments would only extend to issuers in the individual and small group markets that offered transitional coverage or participated in the State and Federal Exchanges, and only for the 2014 reporting year. A transitional policy cost adjustment to the formula for calculating an issuer's MLR would not apply in States that did not implement the transitional policy, or in States that did, to issuers that did not elect to implement it.

With respect to the adjustment for issuers offering transitional coverage, we are proposing that the MLR calculation methodology for the individual and small group markets would be changed to allow these issuers to multiply the incurred claims and expenses for quality improving activities incurred in 2014 in the MLR numerator by 1.0001. This adjustment takes into account the fact that the multiplier would be applied to the issuer's entire experience in 2014, which may also include experience for plans other than transitional coverage in that State and market. In developing this adjustment, we considered the following costs as they relate to the transitional policy: (1) Developing and sending required notices; (2) actuarial work, including that with respect to premium stabilization programs; (3) regulatory and rate filings; and (4) activities related to re-contracting.

With respect to the adjustment for issuers offering coverage through the State and Federal Exchanges, we are proposing that the MLR calculation methodology for the individual and small group markets would be changed to allow issuers participating in the Exchanges to multiply the incurred claims and expenses for quality improving activities incurred in 2014 in the MLR numerator by 1.0004. This adjustment takes into account the fact that the multiplier would be applied to the issuer's entire experience in 2014, which may also include experience for plans offered off the Exchange in that State and market. In developing this adjustment, we considered the following costs as they relate to the technical issues during the launch of the State and Federal Exchanges: (1) Information technology (IT) development and testing; (2) IT system modifications and re-programming; (3) providing feedback to CMS or a State on functionality and data transmission; (4) assistance to enrollees (e.g., enhanced call center activity); (5) engaging in pilot projects relating to direct enrollment; (6) developing technical ''tickets'' for the CMS or a State help desk; (7) work with the Exchange(s) to resolve these technical problems; (8) manual processing of enrollment data, including but not limited to enrollment and payment data template creation, monthly submission of data reports, and monthly submission of data accuracy certification forms; and (9) development of other manual workarounds.

HHS believes that these adjustments would appropriately account for the special circumstances related to implementation of the transitional policy and the rollout of the Exchanges, while still requiring issuers to comply with the statutory MLR requirement.

In addition to seeking comment on the above proposed approach, we also invite comment on other options for making an appropriate adjustment to the MLR formula to account for the unanticipated costs related to the transitional policy and the Exchange implementation.

c. Distribution of *De Minimis* Rebates (§ 158.243)

The MLR December 7, 2011 final rule defines the threshold amounts below which rebates are considered to be *de minimis* and sets forth the provisions for distribution of such rebates. In this proposed rule, we propose to amend the provisions for *de minimis* rebates in § 158.243 to clarify how issuers must distribute rebates where (1) all of an issuer's rebates are *de minimis,* or (2) distribution of *de minimis* rebates to enrollee(s) whose rebates are not *de minimis* would result in an enrollee receiving a rebate that exceeds the enrollee's annual premium. We propose that in these two situations, the issuer must distribute *de minimis* rebates to enrollees in the policies that generated the *de minimis* rebates. The current *de minimis* rebate provisions allow issuers not to distribute *de minimis* rebates to enrollees in the policies that generated those rebates, but instead to aggregate such rebates and distribute them to other enrollees whose rebates are not *de minimis.*

IV. Collection of Information Requirements

Under the Paperwork Reduction Act (PRA) of 1995, we are required to provide 60-day notice in the **Federal Register** and solicit public comment before a collection of information requirement is submitted to the Office of Management and Budget (OMB) for review and approval. This proposed rule contains information collection requirements (ICRs) that are subject to review by OMB. In order to fairly evaluate whether an information collection should be approved by OMB, section 3506(c)(2)(A) of the Paperwork

[55] 75 CFR 74871.

Reduction Act of 1995 requires that we solicit comment on the following issues:

- The need for the information collection and its usefulness in carrying out the proper functions of our agency.
- The accuracy of our estimate of the information collection burden.
- The quality, utility, and clarity of the information to be collected.
- Recommendations to minimize the information collection burden on the affected public, including automated collection techniques.

We are soliciting public comment on each of these issues, which contain ICRs.

A. ICRs Regarding Recertification for Certified Application Counselors (§ 155.225)

Under proposed § 155.225(d)(7), certified application counselors would be required to be recertified on at least an annual basis after successfully completing recertification training as required by the Exchange. Each Exchange would be required to establish its own recertification process and standards consistent with these requirements. We expect that establishing a process for recertification would include creating a recertification request form (or similar document) in Exchanges that directly certify certified application counselors. We estimate that up to 18 State Exchanges would develop their own recertification request form.[56] We estimate that the development of a recertification request form, as may be applicable for Exchanges that directly certify certified application counselors would take a health policy analyst (at $49.35 labor cost per hour) up to 1 hour to create, a senior manager (at $79.08 cost per hour) up to .5 hours (30 minutes) for review, and an attorney up to .5 hours (at $90.15 labor cost per hour) for legal review. We estimate that the one-time cost burden would be two hours with a cost burden of $134 for each Exchange, and the total burden for 18 State Exchanges would be 36 hours with a cost burden of $2,412.

There are recordkeeping requirements associated with developing and maintaining a request form. We estimate that the time burden associated with maintaining a copy of the request form would be .016 hours (1 minute); we assume a mid-level health policy analyst would maintain the form through electronic copies at minimal cost, which we estimate as $0.79 as a one-time requirement for the Exchange. The total burden for 18 Exchanges would be 1.08 hours and the total cost burden would be $14.22.

There would also be third-party disclosure requirements for 18 State Exchanges associated with reviewing each certified application counselor's recertification request, which would require the Exchange to notify the individual of the result of its review and issue a new certificate for each individual who successfully completes recertification. This notice requirement would apply to the Exchange on an annual basis. We estimate that it would take a mid-level health policy analyst in the Exchange up to .08 hours (5 minutes) to notify an individual. The estimated cost burden is $4.11 for each individual notice, including the certificate. For purposes of this analysis, we estimate that there would be approximately 30,000 certified application counselors nationwide, or approximately 10,600 application counselors in 18 State Exchanges. The total cost burden would be approximately $2,422 for each State Exchange. The total burden for 18 State Exchanges would be approximately 883 hours and the total cost burden would be $43,593. There would be recordkeeping requirements associated with issuing each individual notice. We estimate that the time burden associated with maintaining a copy of the notice and certificate would be .016 hours (1 minute); we assume a mid-level health policy analyst, with a labor cost of $49.35 an hour, would maintain the form through electronic copies at minimal cost, which we estimate as $0.79 per notice for each individual certified application counselor. The total recordkeeping burden for 10,600 certified application counselors in 18 State Exchanges would be 170 hours and the total cost burden would be $8,374, or $265 per Exchange.

For Exchanges that designate organizations to directly certify certified application counselors under § 155.225(b)(1), there would be requirements associated with implementing a recertification process under the applicable Exchange's standards. We expect that this process would include creating and issuing a recertification request form (or similar document) for an organization's certified application counselors to submit to indicate their intention to be recertified and provide an updated conflicts of interest disclosure or other attestations as may be required. We estimate that up to 5,000 designated organizations would develop their own recertification request form. We estimate that the development of a recertification request form would take a health policy analyst (at $49.35 labor cost per hour) up to 1 hour to create, a senior manager (at $79.08 labor cost per hour) up to .5 hours (30 minutes) for review, and an attorney (at $90.15 labor cost per hour) up to .5 hours (30 minutes) for legal review. We estimate that the one-time cost burden would be $134 for each organization. The total one-time burden for 5,000 organizations nationwide would be 10,000 hours and the total cost burden would be $670,000.

There would be recordkeeping requirements associated with developing and maintaining a request form. We estimate that the time burden associated with maintaining a copy of the request form would be .016 hours (1 minute); we assume a mid-level health policy analyst with a labor cost of $49.35 an hour would maintain the form through electronic copies at minimal cost, which we estimate as $0.79 as a one-time requirement for each organization. The total one-time burden for 5,000 organizations nationwide would be 80 hours and the total cost burden would be $3,950.

There would also be third-party disclosure requirements for designated organizations associated with reviewing each certified application counselor's recertification request, which would require the organization to notify the individual of the result of its review and issue a new certificate as appropriate. This notice requirement would apply to the organization on an annual basis. For purposes of estimating the burden on designated organizations, we assume that of the estimated 30,000 certified application counselors nationwide, approximately 19,400 would be directly certified by designated organizations, or four certified applications counselors on average per designated organization. We estimate that it would take a mid-level health policy analyst up to .08 hours (5 minutes) to notify an individual and issue a new certificate. The estimated cost burden is $4.11 for each individual notice. For an estimated 19,400 certified application counselors nationwide, or approximately four certified application counselors on average in each organization, the total cost burden would be approximately $16.44 for each organization. The total burden for 5,000 designated organizations nationwide would be approximately 1,617 hours and the total cost burden would be approximately $79,734.

There would be recordkeeping requirements associated with issuing a certificate. We estimate that the time burden associated with maintaining a copy of each certificate issued at recertification would be .016 hours (1

[56] We estimate 18 State Exchanges (which includes Utah) will develop their own processes for recertification. HHS will establish a single process in all FFEs.

minute); we assume a mid-level health policy analyst with a labor cost of $49.35 an hour would maintain the form through electronic copies at minimal cost, which we estimate as $0.79 as a per certificate for each organization. The total recordkeeping cost per organization would be $3.16. The total burden for 5,000 organizations nationwide would be 323 hours and the total cost burden would be approximately $15,326.

There would be third-party disclosure requirements for individual certified application counselors associated with completing the requirements for recertification, whether done directly through the Exchange or through an Exchange-designated certified application counselor organization. Such recertification requirements would include completing Exchange required training and might also include satisfying other requirements consistent with the Exchange-established processes, such as providing conflicts of interest disclosures, other attestations and submitting a recertification request form (or similar document) and other attestations. These requirements would apply to certified application counselors on an annual basis. Although nothing prohibits individual certified application counselors or organizations from being funded through sources such as applicable private, State, or Federal programs, we expect that certified application counselors would not be guaranteed any specific funding. We estimate the professional wage of certified application counselors for this type of work as equivalent to that of an eligibility interviewer for assistance from government programs and agency resources. We estimate that it would take a certified application counselor with a labor cost of $26.65 an hour up to 0.17 hours (10 minutes) to complete and submit the recertification request to the organization or Exchange, as applicable. The estimated cost burden would be $4.53 for each individual seeking recertification. We estimate that there would be approximately 30,000 recertification requests provided, for a total burden of 5,000 hours and a total cost burden of $135,915 for all certified application counselors nationwide.

There would be third-party disclosure requirements associated with taking recertification training. We expect that an individual certified application counselor would provide proof to the organization or Exchange that he or she has successfully completed the recertification training, in accordance with the Exchange's process. We estimate that it would take a certified application counselor with a labor cost of $26.65 an hour up to .03 hours (2 minutes) to provide the training certificate to the organization or Exchange, as may be required. The total estimated cost burden is $0.80 for each individual seeking recertification. We estimate that there would be approximately 30,000 training certificates provided, and the total burden would be 1,000 hours, with a total cost burden of $24,000 for all certified application counselors nationwide.

In addition, there would be recordkeeping requirements associated with the training certification. We expect each person who receives training would obtain and maintain a record of training certification. We estimate that the time burden associated with maintaining proof of training certification is .016 hours (1 minute), since we assume this proof would be maintained through electronic copies, at minimal cost. The total cost estimated for each individual to maintain proof of training certification would be $0.43. The total burden would be 500 hours and the total cost burden would be $12,900 for all certified application counselors nationwide.

B. ICRs Regarding Consumer Authorization (§§ 155.210 and 155.215)

For purposes of the ICRs associated with this proposal, we use the same labor cost estimates that were used in the final Navigator and non-Navigator assistance personnel standards rule (Patient Protection and Affordable Care Act; Exchange Functions: Standards for Navigators and Non-Navigator Assistance Personnel, July 17, 2013, 78 FR 42842). Navigator personnel and non-Navigator assistance personnel to which § 155.215 applies are estimated to have a labor cost of $20 per hour. Navigator and non-Navigator assistance project leads to which § 155.215 applies are estimated to have a labor cost of $29 per hour. Navigator and non-Navigator senior executives to which § 155.215 applies are estimated to have a labor cost of $48 per hour. These are estimates commonly used for estimating paperwork burden and do not represent a recommendation or a requirement of how much Navigator and non-Navigator personnel to which § 155.215 applies are to be paid. There is nothing in the proposed regulations that would require any of these workers to be paid any specific amount.

In the ICR currently approved under OMB control number (OCN) 0938–1220, we noted that there were 105 Navigator grantee organizations at that time in FFEs, including SPEs, and we estimated that there were 3,000 individuals working as Navigators. We estimated the number of non-Navigator assistance project leads to be 300 and 1,800 for personnel and we use those estimates here as well.

In accordance with proposed § 155.210(e)(6) and § 155.215(g), Navigators, as well as those non-Navigator personnel to whom § 155.215 applies, would be required to maintain procedures to inform consumers of the functions and responsibilities of Navigators and non-Navigator assistance personnel (as applicable), and to obtain authorization for the disclosure of consumer information to the Navigator or non-Navigator assistance personnel (as applicable). This would be a one-time requirement for the organization. We estimate that it would take a Navigator or non-Navigator assistance personnel project lead up to 2 hours to create the form for providing authorization to applicants, and a Navigator or non-Navigator senior executive up to 1 hour to review the procedure, for a total time burden of up to 3 hours. We estimate the cost burden associated with creating this procedure would be $106 per organization. The total cost for all 105 Navigator grantee organizations is estimated to be $11,130. The total cost for all 300 non-Navigator assistance personnel organizations is estimated to be $31,800.

There are also recordkeeping requirements associated with developing and maintaining a model agreement and authorization form. Each organization is expected to maintain a copy of the executed forms. We estimate that the time burden associated with maintaining a copy of executed agreement and authorization forms for each consumer would be 0.016 hours (1 minute); we assume these would be maintained through electronic copies with minimal cost.

In addition, there would be burdens on individual Navigators, as well as those non-Navigator assistance personnel to whom § 155.215 applies. Under § 155.210(e)(6) and § 155.215(g), respectively, Navigators and non-Navigator assistance personnel would be required to inform consumers of the functions and responsibilities of Navigators and non-Navigator assistance personnel and obtain authorization for the disclosure of consumer information to a Navigator or non-Navigator assistance personnel prior to obtaining the consumer's personally identifiable information. In the final rule on certified application counselors (78 FR 42824, 42854–42855), we estimated that it would take a certified application counselor 0.25 hours (15 minutes) to provide consumers with information

about the functions and responsibilities of a certified application counselor, obtain their authorizations, and provide any applicable conflict of interest disclosures. Because here we are only estimating the time required to provide consumers with information about the functions and responsibilities of a Navigator or non-Navigator assistance personnel and obtain their authorization, we estimate that it would take a Navigator or non-Navigator assistance personnel 0.1667 hours (10 minutes) to perform this task. The total cost estimate for the consumer authorization process for Navigators and non-Navigator assistance personnel therefore would be $3.33. The total time burden on all 3,000 Navigators is estimated to be approximately 500 hours, and the total cost burden on all 3,000 Navigators is estimated to be $9,990. The total time burden on all 1,800 non-Navigator assistance personnel is estimated to be 300 hours, and the total cost burden on all 1,800 non-Navigator assistance personnel is estimated to be $5,994.

C. ICRs Regarding Enrollee Satisfaction & Marketplace Surveys (§§ 155.1200, 156.1105 and 156.1125)

In § 156.1105 of this proposed rule, we would establish a monitoring and appeals process for HHS-approved enrollee satisfaction survey vendors. Specifically, in § 156.1105(d), we would establish a process in which HHS would monitor approved vendors for ongoing compliance. HHS might require additional information from approved vendors to be periodically submitted in order to ensure continued compliance. We estimate that HHS would approve approximately 40 ESS vendors. We estimate that it would take no longer than one hour for each vendor (at a cost of $24.10 per hour) to comply with any additional monitoring by HHS. Therefore, we estimate a total annual burden of 40 hours for all vendors for a total cost burden estimate of $964.00.

In § 156.1105(e) of this proposed rule, we propose a process by which an enrollee satisfaction survey vendor that is not approved by HHS could appeal HHS's determination. It is estimated that filing an appeal with HHS would take no longer than one hour. We estimate that five survey vendors that apply would not be approved and all of those vendors would appeal HHS's determination and submit additional documentation to HHS. Therefore, we estimate five responses, for a total of five burden hours, for a total cost of $120.50.

The burden estimate associated with quality standards for QHP issuers related to the ESS outlined in § 156.1125 would include the time and effort required for QHP issuers to collect, submit and validate ESS data on an annual basis. The burden and cost related to the survey respondents and ESS vendors associated with the ESS has been approved under OCN 0938–1221. In addition, we estimate that each QHP would need an average of 54 hours or $1,349.60 for the ESS to be administered by mail, phone and/or by web for its QHPs. Assuming a total of 575 QHP issuers, we estimate that the annual burden would be 31,050 hours or $776,020.

The burden with the Marketplace survey under § 155.1200(b)(3) would include the time, cost and effort related to survey respondents and has been approved under OCN 0938–1221. In addition, we will revise the information collection currently approved under OCN 0938–1119 to account for any additional burden for an Exchange if sampling data is needed from State Exchanges for CMS to administer the Marketplace survey.

D. ICR Regarding Quality Rating System (§ 156.1120)

The burden and cost estimates associated with quality standards for QHP issuers related to the QRS outlined in § 156.1120 would include estimates for QRS measure data collection, validation, and submission to CMS. We estimate that a total of 575 QHP issuers would be collecting and reporting QRS measure data, by product type, using administrative data sources and medical records. Using the BLS labor category estimates for a general operations manager, computer programmer, business operations specialist, registered nurse, and medical records and health information analyst, the estimated annual cost and hourly burden for a QHP issuer would be $117,424 and 1650 hours, for an issuer who has performance measures data collection experience. We estimate that approximately eighty percent of all issuers, or 460 issuers, have such experience. We anticipate additional software purchases to generate measure data and rates and increased third-party data validation fees for issuers that do not have the experience in data collection and reporting for the QRS as proposed in § 156.1120. Therefore, we estimate that the additional cost burden for each of the remaining 115 issuers would be approximately $102,500 in the initial year as they develop their data collection systems and processes, for a total of approximately $11,787,500. We estimate $67,518,800 and 948,750 hours as the total annual burden for the anticipated 575 QHP issuers to collect and report QRS data.

E. ICRs Regarding Quality Standards for Exchanges (§§ 155.1400 and 155.1405)

In § 155.1400 and § 155.1405, we propose that each Exchange must display, on its Web site, quality rating and enrollee satisfaction survey result information for QHPs offered on the Exchange. We estimate 18 State Exchanges and the FFE would collect the relevant QRS and ESS information for display. The burden estimate associated with these standards would include collection of the necessary data by each Exchange to display on its Web site. This burden and cost for Exchanges are currently approved under ONC 0938–1156 in the total Web site site that provides information including ESS and quality ratings, on available QHPs. The provisions of this proposed rule would not affect the burden.

F. ICR Regarding Medical Loss Ratio Requirements (§§ 158.150, 158.211, 158.220, 158.221, 158.231 and 158.243)

This proposed rule would amend the MLR provisions regarding the treatment of ICD–10 conversion costs. This proposed rule further proposes MLR calculation adjustments for issuers affected by the transitional policy announced in the CMS letter dated November 14, 2013 and for issuers participating in the State and Federal Exchanges. This proposed rule would also clarify how issuers are to calculate their MLRs in States that require the small group market and individual market to be merged. In addition, this proposed rule would clarify how issuers must distribute *de minimis* rebates. Both MLRs and rebates are reported on the MLR annual reporting form.

The burden for the existing information collection requirement is approved under OCN 0938–1164. This includes the annual reporting form and instructions that are currently used by issuers to submit MLR information to HHS. The MLR annual reporting form collects information on all distributed and owed rebate amounts, regardless of whether they are *de minimis.* Prior to the July 31, 2015 deadline for the submission of the annual MLR report for the 2014 MLR reporting year, and in accordance with the PRA, HHS plans to solicit public comment and seek OMB approval for an updated MLR annual form that would reflect the changes in MLR calculations. In addition, although HHS is seeking OMB approval for updates to the MLR annual form that reflect changes in MLR calculations in States that require the small group market and individual market to be

merged, and changes that would allow issuers to separately report transitional coverage, these changes are not considered new reporting requirements as they utilize information that is a subset of information that issuers already submit to HHS. We do not anticipate that the proposed changes would increase the burden on issuers.

G. ICRs Regarding Civil Money Penalties (§§ 155.206 and 155.285)

Section 155.206 describes the bases and processes HHS proposes to use to impose CMPs on noncompliant consumer assistance personnel and organizations. Section 155.285 describes the bases and processes HHS proposes to use to impose CMPs on persons who provide false or fraudulent information required under section 1411(b) of the Affordable Care Act or who knowingly and willfully use or disclose information in violation of section 1411(g) of the Affordable Care Act. The ICRs proposed in these provisions are exempt from PRA requirements in accordance with 5 CFR 1320.4(a)(2) because this information would be collected during the conduct of an administrative action or investigation involving an agency against specific individuals or entities.

H. ICRs Regarding Fixed Indemnity Insurance, Minimum Essential Coverage, Certifications of Creditable Coverage and HIPAA Opt-Out Election Notice, Notice of Discontinuation, Notice of Renewal (§§ 146.152, 146.180, 147.106, 148.122, 148.124, 148.220, and 156.602)

In § 148.220 of this proposed rule, we propose that issuers of individual market fixed indemnity insurance include a notice in plan materials stating that the coverage is not a substitute for major medical coverage and that lack of minimum essential coverage may result in an additional payment with one's taxes. The notice requirement could be satisfied by inserting a statement into existing plan documents. HHS would provide the exact text of the notice and it would not need to be customized. In addition, under proposed § 156.602, issuers of foreign group health coverage would be required to provide notice to enrollees who are citizens or nationals of the United States of its minimum essential coverage status. Plan documents are usually reviewed and updated annually before a new plan year begins. Issuers would be able to insert the statements in their plan documents at that time at minimal cost. Once the notice is included in the plan documents the first year, no additional cost would be incurred in future years. Sections 146.152, 147.106 and 148.122 of this proposed rule provide that issuers that discontinue a product in the group or individual market, or that provide the option to renew coverage, would also be required to provide written notices to enrollees in a form and manner specified by the Secretary. HHS would provide the exact text of the notices and they would not need to be customized. The burden associated with these notices would not be subject to the Paperwork Reduction Act of 1995 in accordance with 5 CFR 1320.3(c)(2).

Certifications of creditable coverage under § 148.124 would no longer be required to be provided starting December 31, 2014. The burden is currently approved under OCN 0938–0702. In the individual market, the anticipated reduction in annual burden hours would be 835,517, with an anticipated reduction in cost of $25,625,306. The burden for HIPAA Opt-out Election notices under § 146.180 is currently approved under OCN 0938–0702 as well. Electronic submission of opt-out election notice will also reduce costs for plans by eliminating the need for mailing paper forms.

If you comment on these information collection requirements, please do either of the following:

1. Submit your comments electronically as specified in the **ADDRESSES** section of this proposed rule; or

2. Submit your comments to the Office of Information and Regulatory Affairs, Office of Management and Budget, Attention: CMS Desk Officer, CMS–9949–P. Fax: (202) 395–6974; or *Email: OIRA_submission@omb.eop.gov*.

V. Regulatory Impact Analysis

A. Summary

This proposed rule addresses various requirements applicable to health insurance issuers, Exchanges, Navigators, non-Navigator assistance personnel, and other entities under the Affordable Care Act. It also proposes a number of amendments relating to the premium stabilization programs, the medical loss ratio program, certified application counselor programs, affordability exemptions, guaranteed availability and renewability of coverage, and quality reporting requirements. Additionally, it proposes the grounds for imposing CMPs on persons who provide false or fraudulent information to the Exchange and on persons improperly using or disclosing information; to modify standards related to opt-out provisions for self-funded non-Federal governmental plans and individual market provisions under the Health Insurance Portability and Accountability Act of 1996; and standards for recognition of certain types of foreign group coverage as minimum essential coverage.

CMS has crafted this rule to implement the protections intended by Congress in an economically efficient manner. We have examined the effects of this rule as required by Executive Order 12866 (58 FR 51735, September 1993, Regulatory Planning and Review), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, the Unfunded Mandates Reform Act of 1995 (Pub. L. 104–4), Executive Order 13132 on Federalism, and the Congressional Review Act (5 U.S.C. 804(2)). In accordance with OMB Circular A–4, CMS has quantified the benefits, costs and transfers where possible, and has also provided a qualitative discussion of some of the benefits, costs and transfers that may stem from this proposed rule.

B. Executive Orders 13563 and 12866

Executive Order 12866 (58 FR 51735) directs agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects; distributive impacts; and equity). Executive Order 13563 (76 FR 3821, January 21, 2011) is supplemental to and reaffirms the principles, structures, and definitions governing regulatory review as established in Executive Order 12866.

Section 3(f) of Executive Order 12866 defines a ''significant regulatory action'' as an action that is likely to result in a proposed rule—(1) having an annual effect on the economy of $100 million or more in any one year, or adversely and materially affecting a sector of the economy, productivity, competition, jobs, the environment, public health or safety, or State, local or tribal governments or communities (also referred to as ''economically significant''); (2) creating a serious inconsistency or otherwise interfering with an action taken or planned by another agency; (3) materially altering the budgetary impacts of entitlement grants, user fees, or loan programs or the rights and obligations of recipients thereof; or (4) raising novel legal or policy issues arising out of legal mandates, the President's priorities, or the principles set forth in the Executive Order.

A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any 1 year), and a ''significant'' regulatory action is subject to review by the OMB. HHS has concluded that this rule is likely to have economic impacts of $100 million or more in any one year, and therefore meets the definition of ''significant rule'' under Executive Order 12866. Therefore, HHS has provided an assessment of the potential costs, benefits, and transfers associated with this proposed regulation.

1. Need for Regulatory Action

Starting in 2014, qualified individuals and qualified employers are able to obtain coverage provided through Exchanges. The proposed provisions, amendments and clarifications in this proposed rule would address stakeholder concerns and inquiries and ensure smooth functioning of health insurance markets and Exchanges and ensure that individuals have access to high quality and affordable health insurance coverage. In addition, this proposed rule would establish methodologies for calculating the MLR to address ICD–10 conversion costs, MLR and rebate calculations in States that require the individual and small group markets to be merged, the distribution of *de minimis* rebates, and to accommodate the special circumstances of issuers affected by the transitional policy announced in the CMS letter dated November 14, 2013, and issuers participating in the State and Federal Exchanges.

2. Summary of Impacts

In accordance with OMB Circular A–4, Table V.1 below depicts an accounting statement summarizing CMS's assessment of the benefits, costs, and transfers associated with this regulatory action. The period covered by the RIA is 2014–2018.

HHS anticipates that the provisions of this proposed rule will ensure that all consumers have access to quality and affordable health care and are able to make informed choices, ensure smooth operation of Exchanges, ensure that premium stabilization programs work as intended, provide flexibility to SHOPs and employers, and protect consumers from fraudulent and criminal activities. Affected entities such as QHP issuers, Navigators and non-Navigator assistance personnel, designated certified application counselor organizations, survey vendors, and States, would incur costs to comply with the proposed provisions, including administrative costs related to notices, surveys, training, and recertification requirements. In accordance with Executive Order 12866, HHS believes that the benefits of this regulatory action justify the costs.

TABLE V.1—ACCOUNTING TABLE

Benefits:

Qualitative:

* Ensure access to affordable and quality health insurance coverage for all individuals.
* Allow consumers to make informed choices.
* Lower out-of-pocket costs for individuals who purchase fixed indemnity insurance.
* Possible reduction in cost sharing due to adjustment in methodology for calculating annual limitations on cost-sharing and small group deductibles.
* Ensure sufficiency of funds in the reinsurance payment pool.
* Ensure consumer protection and privacy and security of PII.
* Discourage fraudulent or criminal activity by consumer assistance personnel and entities.
* Provide additional flexibility to SHOPs and employers and allow employers to select plans with updated rate information.
* Improve consistency of MLR calculations among issuers in States with merged individual and small group markets and improve accuracy of rebate payments.

Costs:	Estimate	Year dollar	Discount rate percent	Period covered
Annualized Monetized ($millions/year)	$48.78 million [1]	2013	7	2014–2018
	$49.52 million [1]	2013	3	2014–2018

Net annual costs to enrollees related to ESS and Marketplace survey; recertification of certified application counselors by States; administrative costs incurred by survey vendors to appeal application denials; administrative costs to QHP issuers related to data submissions for QRS and ESS administration; costs related to notice and disclosure requirements for certified application counselor recertification; consumer authorization for Navigators and non-Navigator personnel; and a reduction in costs for issuers in the individual market due to discontinuation of certification of creditable coverage.

Qualitative:

* Costs to certified application counselors to obtain required training for recertification.
* Reduction in costs to consumers due to ability to make requests to dismiss appeals by telephone.
* Possible increase in premiums due to adjustments in methodology for calculating annual limitations on cost-sharing and small group deductibles.

TABLE V.1—ACCOUNTING TABLE - CONTINUED

Transfers:	Estimate	Year dollar	Discount rate percent	Period covered
Annualized Monetized ($millions/year)	$2.93 million	2013	7	2014–2018
	$2.99 million	2013	3	2014–2018

Net annual transfer of rebate dollars to enrollees from shareholders or nonprofit stakeholders, resulting from adjustment in MLR methodology for issuers in States with merged individual and small group markets.

Qualitative:

* Possible reduction in rebates paid by issuers to enrollees due to adjustment in MLR methodology for issuers affected by the November 2013 transitional policy and unexpected costs during the implementation of the Exchanges, and to account for ICD–10 conversion costs.
* Possible transfer of transitional reinsurance program funds from the Federal government to non-grandfathered reinsurance-eligible plans in the individual market.
* Possible increase in total risk corridors payment amounts made by the Federal government and decrease in total risk corridors receipts, although the Federal government intends to implement the risk corridors program in a budget neutral manner.

1. *Note:* Approximately $13 million in costs are estimated in the RIA below and the remaining costs related to ICRs are estimated in section IV above.

3. Anticipated Benefits, Costs and Transfers

The impacts of the existing regulations that are being amended and clarified in this proposed rule have already been addressed in RIAs included in previous rulemaking. This RIA only includes the impacts of new provisions and any changes to previous estimates as a result of amendments to existing provisions.

Benefits

Provisions of this proposed rule would ensure that all individuals have access to affordable and quality health insurance coverage and the necessary information to make informed choices. Making quality rating and enrollee satisfaction survey information available to consumers would allow them to make informed choices and provide issuers with an incentive to improve quality of care and consumer experience. The results from the Marketplace survey would drive quality improvement in Exchanges and provide regulators and stakeholders with information to use for monitoring and oversight purposes. The proposed amendments to special enrollment periods would ensure that individuals who experience loss of coverage or exceptional circumstances have continued access to healthcare. The proposal to designate foreign group health coverage for individuals on expatriate status as minimum essential coverage would ensure that such individuals have appropriate coverage while abroad or visiting the United States.

The proposed amendments for fixed indemnity insurance would allow such plans to be sold as secondary to other health insurance coverage that meets the definition of minimum essential coverage. This would allow individuals that buy such coverage to lower their out-of-pocket costs.

The proposed adjustments to the transitional reinsurance program would ensure that the reinsurance pool is sufficient to provide the premium stabilization benefits intended by statute. The proposed adjustments to the risk corridors formula for the 2015 benefit year would help to mitigate issuers' unexpected administrative costs and uncertainties around operations and the risk pool, and to stabilize the market as it continues to transition to full compliance with Affordable Care Act requirements.

The proposed regulations would clarify some of the standards for Navigator and certified application counselor conduct that would ensure consumer protection and ensure that Navigators provide information and services concerning enrollment in QHPs in a fair and impartial manner and that certified application counselors act in consumers' best interests. The proposed rule would also provide HHS with the authority to impose CMPs on Navigators, non-Navigator assistance personnel, certified application counselors, and certified application counselor organizations in the FFE who violate the Exchange standards applicable to them. This would ensure that consumers interacting with the Exchange receive high-quality assistance and robust consumer protection. The proposed provisions to impose CMPs for provision of false or fraudulent information, and improper use or disclosure of information would also ensure privacy and security of consumers' PII.

The proposed amendments to the annual employer and employee enrollment periods in the SHOP would benefit SHOPs by providing issuers with the same amount of time to complete the SHOP QHP certification process as that available for the individual Exchange. Aligning the start dates for the employer election period with the start of individual market Exchange open enrollment for 2015 would provide Exchanges with a uniform timeline for improving and launching Exchange services for 2015. Additionally, a uniform QHP filing and review timeline for both markets for 2015 would reduce confusion and provide efficiencies to scale in review, providing potential resource savings to Exchanges and QHP issuers. Removing the required minimum lengths of both the employer election period and the employee open enrollment period would provide additional flexibility to SHOPs and employers and allow employers to select plans with the most up-to-date rate information.

The proposed amendment to provide for a one year transition policy under which a SHOP would be permitted to not implement employee choice in 2015 would alleviate concerns that HHS has with specific circumstances where employee choice would result in significant adverse selection in the State's small group market that cannot be remediated through the premium stabilization programs or the single risk pool, or that there would not be a meaningful choice of QHPs and/or stand-alone dental plans in the State's SHOP. Allowing for this transitional policy in 2015 will provide minimal disruption to small group markets.

The proposed amendment to our methodology for calculating the annual limitation on cost sharing and the annual limitation on small group deductibles could reduce cost sharing paid by some enrollees in the individual and group markets.

The proposed amendments to the MLR methodology in States that require the small group market and individual market to be merged would improve the

consistency of MLR calculations among issuers in those States and improve the accuracy of rebate payments.

The approaches we are considering to define the required contribution percentage would provide that determinations of affordability exemptions would take into account the rate of premium growth over the rate of income growth. We do not anticipate that these approaches would significantly alter the number of individuals who would be expected to enroll in health insurance plans or make shared responsibility payments.

Costs

Affected entities would incur costs to comply with the provisions of this proposed rule. Costs related to ICRs subject to PRA are discussed in detail in section IV and include administrative costs incurred by survey vendors to appeal application denials; costs to QHP issuers related to data submissions for QRS, ESS administration; costs related to notice and disclosure requirements for certified application counselor recertification, consumer authorization for Navigators and non-Navigator assistance personnel; and a reduction in costs for issuers in the individual due to discontinuation of certification of creditable coverage. In this section, we discuss other costs related to the proposed provisions.

Each Exchange must establish its own recertification process for certified application counselors and designated certified application counselor organizations. We expect that establishing a process for recertification would include updating recertification training materials in all Exchanges. We estimate that up to 18 State Exchanges will develop their own training materials. We expect that an Exchange would develop training materials for recertification on an annual basis. We assume that it would take a mid-level health insurance analyst (with an hourly labor cost of $49.35) 8 hours to update the training, 4 hours for a computer programmer (at $52.50 per hour) to update the online training module and 1 hour by a senior manager (at $79.08 per hour) to review. The total cost for each State Exchange is estimated to be approximately $680, and the total cost for 18 State Exchanges would be approximately $12,240.

The proposed requirement for appeals entities to dismiss an appeal if the request is received via telephonic signature (if the appeals entity is capable of accepting telephonic withdrawals) would make the process more efficient and may reduce costs to the appellant.

The enrollee satisfaction survey would impact enrollees responding to the survey, survey vendors and QHP issuers. In 2014, a psychometric test of the survey would be carried out, while in 2015 a beta test would be performed. The cost to issuers is addressed in section IV. We anticipate that in 2014, 4,200 enrollees would participate in the psychometric test and in 2015 onwards, 6,000,040 enrollees would complete the survey. The total cost in 2014 of administering the survey to enrollees is estimated to be approximately $45,549 and the total cost to enrollees and survey vendors is estimated to be approximately $6,507,964 in 2015 and future years. In 2014, only one survey vendor would conduct the psychometric test and in the following years, about 40 vendors are expected to conduct the survey.[57] In addition, each QHP issuer would have to contract with an ESS vendor. We estimate approximately $16,000 as the annual cost for a QHP issuer to contract with an ESS vendor, for a total annual cost of $9.2 million for 575 QHP issuers.

The Marketplace survey would be administered by a survey vendor under contract with HHS. A psychometric test would be conducted in 2014 with a beta test in 2015. Consumers would incur burden to respond to the survey. We estimate that each response would take 0.4 hours for a total of 3,150 responses requiring 1,260 hours in 2014 and a total of 61,200 responses requiring 24,480 hours in 2015 onwards. Total costs would be approximately $30,366 in 2014 and $589,968 in following years.[58]

The proposed amendment to our methodology for calculating the annual limitation on cost sharing and the annual limitation on small group deductibles could lead some issuers to increase premiums slightly, potentially resulting in higher premiums for consumers.

Transfers

Currently, the MLR regulation permits inclusion of ICD–10 conversion costs in quality improving activity expenses only through the 2013 MLR reporting year. However, the Secretary has changed the date by which issuers are required to adopt ICD–10 as the standard medical code set from October 1, 2013 to October 1, 2014. Therefore, this proposed rule proposes to permit issuers to include their ICD–10 conversion costs through the MLR reporting year in which the Secretary requires conversion to be completed, which is currently expected to be 2014. Based on the 2012 MLR data, we estimate that the current ICD–10 provision reduced total rebates for 2012 by less than 2 percent. To the extent issuers may have completed a substantial portion of ICD–10 conversion prior to 2014, we expect that the impact of the proposed change on the 2014 rebates would be even smaller.

This proposed rule also proposes to account for the special circumstances of issuers affected by the CMS November 2013 transitional policy by allowing those issuers to multiply the incurred claims and expenses for quality improving activities incurred in 2014 in the MLR numerator by 1.0001. This adjustment would be limited to issuers that provided transitional coverage in the individual or small group markets in States that adopted the transitional policy. In addition, this proposed rule proposes to account for the special circumstances of the issuers that provided coverage through the State and Federal Exchanges by allowing those issuers to multiply the incurred claims and expenses for quality improving activities incurred in 2014 in the numerator by 1.0004. This adjustment would be limited to issuers offering coverage in the individual or small group markets through the Exchanges. Based on the 2012 MLR data, we estimate that the proposed adjustment for issuers affected by the transitional policy and for issuers affected by the Exchanges rollout might reduce the total rebates by 0.5 percent for 2014.

In addition, this proposed rule proposes to amend the MLR methodology to clarify how issuers must calculate MLRs in States that require the small group market and individual market to be merged for MLR calculation purposes. This would improve the consistency of MLR calculations among issuers in those States and improve the accuracy of rebate payments. Currently, only Massachusetts, Vermont, and the District of Columbia require the small group market and individual market to be merged (the Vermont and the District of Columbia requirements take effect in 2014). If an issuer met the respective MLR standards in the separate markets,

[57] Detailed burden estimates can be found in the Supporting Statement for the Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection, found at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html*.

[58] Detailed burden estimates can be found in the Supporting Statement for the Health Insurance Marketplace Consumer Experience Surveys: Enrollee Satisfaction Survey and Marketplace Survey Data Collection, found at *https://www.cms.gov/Regulations-and-Guidance/Legislation/PaperworkReductionActof1995/PRA-Listing.html*.

then this provision would not have any impact on rebates. However, if an issuer met the MLR standards only in one market and merging the two markets would result in the issuer meeting (or being unable to meet) the MLR standards in the merged market, the issuer might have to pay lower (or higher) rebates and there would be a transfer from enrollees to issuers (or from issuers to enrollees). Based on the 2012 MLR data, we anticipate that the proposed change might result in issuers paying an additional $3.8 million in rebates.

This proposed rule also proposes that issuers must distribute rebates directly to enrollees where (1) all of an issuer's rebates are *de minimis,* or (2) distribution of *de minimis* rebates to enrollee(s) whose rebates are not *de minimis* would result in an enrollee receiving a rebate that exceeds the enrollee's annual premium. The current *de minimis* rebate provisions allow issuers not to distribute *de minimis* rebates to enrollees, but instead to aggregate such rebates and distribute them to enrollees whose rebates are not *de minimis.* With respect to the first proposed *de minimis* provision, the current *de minimis* rebate provisions do not account for a situation where all of an issuer's rebates are *de minimis.* It is presumed that in such a circumstance, issuers would distribute the *de minimis* rebates to all enrollees whose rebates are *de minimis* since these issuers would not have any enrollees with non-*de minimis* rebates; therefore, we do not consider the proposed clarification to create any additional burden. We are currently aware of one issuer that was in this situation, but more issuers may benefit from this clarification as they begin to come closer to meeting the MLR standard in future years. With respect to the second proposed *de minimis* provision, we are not currently aware of any issuers that experienced this circumstance. Further, there should not be any impact to the total amount of rebates disbursed because the changes proposed here only impact the recipient of rebates and not the total amount paid.

In this proposed rule, we propose to revise our allocation of reinsurance contributions collected for the 2014 and 2015 benefit years so that reinsurance contributions collected are allocated first to the reinsurance pool and administrative expenses and second to payments to the U.S. Treasury. We expect that this proposal would not have a significant effect on transfers, because we estimate that we will collect the full amount of reinsurance contributions. This proposal could lower premiums by reducing the uncertainty associated with reinsurance payments to non-grandfathered plans in the individual market that are eligible for such payments under 45 CFR 153.234.

The Affordable Care Act creates a temporary risk corridors program for the years 2014, 2015, and 2016 that applies to QHPs, as defined in § 153.500. The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers. The Affordable Care Act establishes the risk corridors program as a Federal program; consequently, HHS will operate the risk corridors program under Federal rules with no State variation. The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains. For the 2015 benefit year, we are proposing an adjustment to the risk corridors formula that would help mitigate potential QHP issuers' unexpected administrative costs. Although our initial modeling suggests that this adjustment could increase the total risk corridors payment amount made by the Federal government and decrease risk corridors receipts, we estimate that, even with this change, the program can be implemented in a budget neutral manner.

C. Regulatory Alternatives

Under the Executive Order, CMS is required to consider alternatives to issuing rules and alternative regulatory approaches. CMS considered the regulatory alternatives below:

1. Collecting ESS Data at the Product Level Instead of Each Product per Metal Tier

Under this alternative, HHS would require QHPs to collect ESS data from a single sample for each product (versus each product in each metal tier). This option would reduce the cost for issuers who offer the same product in multiple tiers. However, collecting data at the product level would prevent consumers from understanding differences in enrollee satisfaction at the individual product per tier level, which may vary with differences in cost sharing. This would reduce the benefits that consumers derive from ESS data.

2. Using Medicaid CAHPS as Is Instead of Adding Additional and New Questions to the ESS

Under this alternative, HHS would require QHPs to collect enrollee satisfaction information using the Medicaid CAHPS instrument without further enhancement. The ESS will include more questions than the Medicaid CAHPS—including detailed questions about the patient's costs—that are particularly appropriate to Exchange enrollees. Eliminating these questions would reduce the cost to issuers, but also reduce benefits that consumers derive from the ESS data.

3. Collecting QRS Data for Each Product per Metal Tier Instead of at the Product Level

Under this alternative, HHS would require QHPs to collect the QRS data at the same level (individual product per metal tier) as they collect ESS information. Assuming that QHPs offer each product in two metal tiers this option would double the cost to QHPs of collecting QRS data. However, it might not appreciably increase consumer information about QHPs in the early years of the Exchanges if the quality of care in the same product does not differ significantly within tiers (i.e., the variation should only be by the configuration of cost sharing within a limited range of actuarial value). Further, a QHP's enrollment size at the product metal level may be too small in the early years of Exchange implementation to ensure reliable results.

4. Using the Medicare Advantage (MA) CAHPS Instrument and Star System

Under this alternative, HHS would require QHPs to collect enrollee satisfaction information from Exchange enrollees using the MA CAHPS instrument. The ESS presently includes 29 more questions, than MA CAHPS. Use of the MA CAHPS would reduce the cost to consumers and also the QHP cost of data entry. However, the MA CAHPS instrument and Star ratings are designed for a different population and are not necessarily suitable to measure experience among Exchange enrollees. It also would have limited applicability for use by consumers for QHP comparison and selection purposes.

CMS believes that the options adopted for this proposed rule would be more efficient ways to extend the protections of the Affordable Care Act to enrollees without imposing significant burden on issuers and States.

D. Regulatory Flexibility Act

The Regulatory Flexibility Act (RFA) requires agencies that issue a rule to analyze options for regulatory relief of small businesses if a rule has a significant impact on a substantial number of small entities. The RFA generally defines a ''small entity'' as—(1) a proprietary firm meeting the size

standards of the Small Business Administration (SBA), (2) a nonprofit organization that is not dominant in its field, or (3) a small government jurisdiction with a population of less than 50,000 (States and individuals are not included in the definition of ''small entity''). CMS uses as its measure of significant economic impact on a substantial number of small entities a change in revenues of more than 3 percent to 5 percent.

As discussed in the Web Portal interim final rule with comment period published on May 5, 2010 (75 FR 24481), CMS examined the health insurance industry in depth in the RIA we prepared for the proposed rule on establishment of the Medicare Advantage program (69 FR 46866, August 3, 2004). In that analysis it was determined that there were few, if any, insurance firms underwriting comprehensive health insurance policies (in contrast, for example, to travel insurance policies or dental discount policies) that fell below the size thresholds for ''small entity'' established by the SBA. Based on data from MLR annual report submissions for the 2012 MLR reporting year,[59] out of 510 companies offering comprehensive health insurance policies nationwide, there are 58 small entities, each with less than $35.5 million in earned premiums, that offer individual or group health insurance coverage and would therefore be subject to the provisions of this proposed rule.[60] Forty-three percent of these small entities belong to holding groups, and many if not all of these small entities are likely to have other lines of business (e.g., insurance business other than health insurance, and business other than insurance) that would result in their revenues exceeding $35.5 million. Based on this analysis, HHS expects that the proposed provisions would not affect a substantial number of small issuers.

The proposed amendments to the annual employer and employee election periods in the SHOP, including removing the required minimum lengths of both the employer election period and the employee open enrollment period would benefit SHOPs and employers. HHS does not anticipate that this will impose any costs on small employers.

Some of the entities that voluntarily act as Navigators and non-Navigator assistance personnel subject to § 155.215, or as designated certified application counselor organizations, might be small entities and would incur costs to comply with the provisions of this proposed rule. It should be noted that HHS, in its role as the operator of the FFEs, does not impose any fees on these entities for participating in their respective programs, nor are there fees for taking the Federally required training or completing continuing education or recertification in FFEs. Further, the cost burden related to continuing education and recertification, and recordkeeping would generally be considered an allowed cost that would be covered by the Navigator grants for the FFEs, and these grant funds may be drawn down as the grantee incurs such costs. The costs associated with these proposals might also be covered by other compensation provided by an Exchange, such as payments through contracts to non-Navigator assistance personnel. Though it is very likely that all costs associated with these proposals would be largely covered by affected entities' and individuals' funding sources, HHS cannot guarantee that all such costs would be covered because of the possibility of budget limitations applicable to the FFE in any given period, and because there may be variations in how State Exchanges provide funding for these programs. To the extent that all such costs would not covered by these funding sources, other outside sources may also be available to cover unfunded costs that remain. Costs incurred by designated certified application counselor organizations related to continuing education and recertification and recordkeeping are expected to be low. In some circumstances funds from sources outside of the Exchange, including Federal funds such as Health Resources and Services Administration (HRSA) grants to health centers, or private or State funds might be available to cover certified application counselor costs.

E. Unfunded Mandates Reform Act

Section 202 of the Unfunded Mandates Reform Act (UMRA) of 1995 requires that agencies assess anticipated costs and benefits before issuing any proposed rule that includes a Federal mandate that could result in expenditure in any one year by State, local or tribal governments, in the aggregate, or by the private sector, of $100 million in 1995 dollars, updated annually for inflation. In 2014, that threshold level is approximately $141 million.

UMRA does not address the total cost of a proposed rule. Rather, it focuses on certain categories of cost, mainly those ''Federal mandate'' costs resulting from—(1) imposing enforceable duties on State, local, or tribal governments, or on the private sector; or (2) increasing the stringency of conditions in, or decreasing the funding of, State, local, or tribal governments under entitlement programs.

This proposed rule includes mandates on State, local, or tribal governments. Issuers, certified application counselors and Exchanges are expected to incur costs of approximately $13 million in 2014 and approximately $85 million in 2015 onwards to comply with the provisions of this proposed rule. However, beginning in 2015, issuers in the individual market would experience a reduction in costs of approximately $26 million due to the discontinuation of the certification of creditable coverage. Consistent with policy embodied in UMRA, this proposed rule has been designed to be the least burdensome alternative for State, local and tribal governments, and the private sector while achieving the objectives of the Affordable Care Act.

F. Federalism

Executive Order 13132 establishes certain requirements that an agency must meet when it promulgates a proposed rule that imposes substantial direct requirement costs on State and local governments, preempts State law, or otherwise has Federalism implications.

States are the primary regulators of health insurance coverage. States will continue to apply State laws regarding health insurance coverage. However, if any State law or requirement prevents the application of a Federal standard, then that particular State law or requirement would be preempted. State requirements that are more stringent than the Federal requirements would be not be preempted by this proposed rule, unless they conflict with or prevent application of the provisions of title I of the Affordable Care Act within the meaning of section 1321(d) of the Affordable Care Act. Accordingly, States have significant latitude to impose requirements with respect to health insurance coverage that are more restrictive than the Federal law requirements.

The proposed amendment to § 155.225(d) would clarify that certified application counselors must meet any licensing, certification or other

[59] These data can be accessed at *http://www.cms.gov/CCIIO/Resources/Data-Resources/mlr.html*.

[60] The size threshold for ''small'' business established by the SBA is currently $35.5 million in annual receipts for health insurance issuers. See ''Table of Small Business Size Standards Matched To North American Industry Classification System Codes,'' effective July 23, 2013, U.S. Small Business Administration, available at *http://www.sba.gov*.

standards prescribed by the State so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act, within the meaning of section 1321(d) of the Affordable Care Act. The proposed provisions also specify State requirements applicable to Navigators, non-Navigator assistance personnel, or certified application counselors that would prevent the application of the provisions of title I of the Affordable Care Act, within the meaning of section 1321(d) of the Affordable Care Act. They include requirements that require referrals to entities or individuals not required to provide impartial information or act in a consumer's best interest, or prevent Navigators, non-Navigator assistance personnel, or certified application counselors from providing services to all individuals seeking assistance, or providing advice regarding substantive benefits or comparative benefits of different health plans; in FFEs conflict with Federal standards or make it impossible to fulfill required duties, as such requirements are applied or implemented in the State; in FFEs, render ineligible otherwise eligible individuals or entities from participating as Navigators, non-Navigator assistance personnel subject to § 155.215 or certified application counselors under standards applicable to an FFE; and requiring that Navigators hold an agent or broker license or carry errors or omissions insurance.

Some States already have requirements for and publicly report health plan quality and outcomes data, and we want to encourage State flexibility and innovation, consistent with the Affordable Care Act. In addition to prominently displaying quality rating information for each QHP, as calculated by HHS in accordance with the QRS, a State Exchange may display additional QHP quality-related information, as appropriate.

In compliance with the requirement of Executive Order 13132 that agencies examine closely any policies that may have Federalism implications or limit the policymaking discretion of the States, HHS has engaged in efforts to consult with and work cooperatively with affected States. HHS has consulted with stakeholders on policies related to the operation of Exchanges, including the SHOP and the premium stabilization programs. HHS has held a number of listening sessions with State representatives to gather public input. HHS consulted with State representatives through regular meetings with the National Association of Insurance Commissioners (NAIC) and regular contact with States through the Exchange Establishment grant and Exchange Blueprint approval processes.

Throughout the process of developing this proposed rule, CMS has attempted to balance the States' interests in regulating health insurance issuers. By doing so, it is CMS' view that it has complied with the requirements of Executive Order 13132. Under the requirements set forth in section 8(a) of Executive Order 13132, and by the signatures affixed to this rule, HHS certifies that the CMS Center for Consumer Information and Insurance Oversight has complied with the requirements of Executive Order 13132 for the attached proposed rule in a meaningful and timely manner.

G. Congressional Review Act

This proposed rule is subject to the Congressional Review Act provisions of the Small Business Regulatory Enforcement Fairness Act of 1996 (5 U.S.C. 801 et seq.), which specifies that before a rule can take effect, the Federal agency promulgating the rule shall submit to each House of the Congress and to the Comptroller General a report containing a copy of the rule along with other specified information, and has been transmitted to Congress and the Comptroller General for review.

List of Subjects

45 CFR Part 146

Health care, Health insurance, Reporting and recordkeeping requirements.

45 CFR Part 147

Health care, Health insurance, Reporting and recordkeeping requirements, State regulation of health insurance.

45 CFR Part 148

Administrative practice and procedure, Health care, Health insurance, Penalties, Reporting and recordkeeping requirements.

45 CFR Part 153

Administrative practice and procedure, Adverse selection, Health care, Health insurance, Health records, Organization and functions (Government agencies), Premium stabilization, Reporting and recordkeeping requirements, Reinsurance, Risk adjustment, Risk corridors, Risk mitigation, State and local governments.

45 CFR Part 155

Administrative practice and procedure, Health care access, Health insurance, Reporting and recordkeeping requirements, State and local governments, Cost-sharing reductions, Advance payments of premium tax credit, Administration and calculation of advance payments of the premium tax credit, Plan variations, Actuarial value.

45 CFR Part 156

Administrative appeals, Administrative practice and procedure, Administration and calculation of advance payments of premium tax credit, Advertising, Advisory committees, Brokers, Conflict of interest, Consumer protection, Cost-sharing reductions, Grant programs—health, Grants administration, Health care, Health insurance, Health maintenance organization (HMO), Health records, Hospitals, American Indian/Alaska Natives, Individuals with disabilities, Loan programs—health, Organization and functions (Government agencies), Medicaid, Payment and collections reports, Public assistance programs, Reporting and recordkeeping requirements, State and local governments, Sunshine Act, Technical assistance, Women, and Youth.

45 CFR Part 158

Administrative practice and procedure, Claims, Health care, Health insurance, Health plans, Penalties, Reporting and recordkeeping requirements, Premium revenues, Medical loss ratio, Rebating.

For the reasons set forth in the preamble, the Department of Health and Human Services proposes to amend 45 CFR parts 146, 147, 148, 153, 155, 156, and 158 as set forth below:

PART 146—REQUIREMENTS FOR THE GROUP HEALTH INSURANCE MARKET

■ 1. The authority citation for part 146 continues to read as follows:

Authority: Secs. 2702 through 2705, 2711 through 2723, 2791, and 2792 of the PHS Act (42 U.S.C. 300gg–1 through 300gg–5, 300gg–11 through 300gg–23, 300gg–91, and 300gg–92).

■ 2. Section 146.152 is amended by—
■ A. Revising paragraphs (c)(1) and (f).
■ B. Redesignating paragraph (g) as paragraph (h).
■ C. Adding new paragraph (g).

The revision and addition reads as follows:

§ 146.152 Guaranteed renewability of coverage for employers in the group market.

* * * * *

(c) * * *

(1) The issuer provides notice in writing, in a form and manner specified

by the Secretary, to each plan sponsor provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 days before the date the coverage will be discontinued;

* * * * *

(f) *Exception for uniform modification of coverage.* (1) Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan in the following—

(i) Large group market; and

(ii) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is effective uniformly among group health plans with that product.

(2) For purposes of this paragraph (f), modifications made solely pursuant to applicable Federal or State law are considered a uniform modification of coverage. Other types of modifications are considered a uniform modification of coverage if the product that has been modified meets all of the following criteria:

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act).

(ii) The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO)).

(iii) The product covers a majority of the same counties in its service area;

(iv) The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act.

(v) The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

(3) A State may establish criteria that broaden, but not restrict, the definition of a uniform modification of coverage under paragraph (f)(2) of this section.

(g) *Notice of renewal of coverage.* If an issuer is renewing coverage as described in paragraph (a) of this section, or uniformly modifying coverage as described in paragraph (f) of this section, the issuer must provide to each plan sponsor written notice of the renewal in a form and manner specified by the Secretary.

* * * * *

■ 3. Section 146.180 is revised to read as follows:

§ 146.180 Treatment of non-Federal governmental plans.

(a) *Opt-out election for self-funded non-Federal governmental plans*—(1) *Requirements subject to exemption.* The PHS Act requirements described in this paragraph are the following:

(i) Limitations on preexisting condition exclusion periods in accordance with section 2701 of the PHS Act as codified before enactment of the Affordable Care Act.

(ii) Special enrollment periods for individuals and dependents described under section 2704(f) of the PHS Act.

(iii) Prohibitions against discriminating against individual participants and beneficiaries based on health status under section 2705 of the PHS Act, except that the sponsor of a self-funded non-Federal governmental plan cannot elect to exempt its plan from requirements under section 2705(a)(6) and 2705(c) through (f) that prohibit discrimination with respect to genetic information.

(iv) Standards relating to benefits for mothers and newborns under section 2725 of the PHS Act.

(v) Parity in mental health and substance use disorder benefits under section 2726 of the PHS Act.

(vi) Required coverage for reconstructive surgery following mastectomies under section 2727 of the PHS Act.

(vii) Coverage of dependent students on a medically necessary leave of absence under section 2728 of the PHS Act.

(2) *General rule.* For plan years beginning on or after September 23, 2010, a sponsor of a non-Federal governmental plan may elect to exempt its plan, to the extent the plan is not provided through health insurance coverage (that is, it is self-funded), from one or more of the requirements described in paragraphs (a)(1)(iv) through (vii) of this section.

(3) *Special rule for certain collectively bargained plans.* In the case of a plan that is maintained pursuant to a collective bargaining agreement that was ratified before March 23, 2010, and whose sponsor made an election to exempt its plan from any of the requirements described in paragraphs (a)(1)(i) through (iii) of this section, the provisions of paragraph (a)(2) of this section apply for plan years beginning after the expiration of the term of the agreement.

(4) *Examples*—(i) *Example 1.* A non-Federal governmental employer has elected to exempt its self-funded group health plan from all of the requirements described in paragraph (a)(1) of this section. The plan year commences September 1 of each year. The plan is not subject to the provisions of paragraph (a)(1)(ii) of this section until the plan year that commences on September 1, 2011. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect to exempt its plan only from the requirements described in paragraphs (a)(1)(iv) through (vii) of this section.

(ii) *Example 2.* A non-Federal governmental employer has elected to exempt its collectively bargained self-funded plan from all of the requirements described in paragraph (a)(1) of this section. The collective bargaining agreement applies to five plan years, October 1, 2009 through September 30, 2014. For the plan year that begins on October 1, 2014, the plan sponsor is no longer permitted to elect to exempt its plan from the requirements described in paragraph (a)(1) of this section. Accordingly, for that plan year and any subsequent plan years, the plan sponsor may elect to exempt its plan only from the requirements described in paragraphs (a)(1)(iv) through (vii) of this section.

(5) *Limitations.* (i) An election under this section cannot circumvent a requirement of the PHS Act to the extent the requirement applied to the plan before the effective date of the election.

Example 1. A plan is subject to requirements of section 2727 of the PHS Act, under which a plan that covers medical and surgical benefits with respect to a mastectomy must cover reconstructive surgery and certain other services following a mastectomy. An enrollee who has had a mastectomy receives reconstructive surgery on August 24. Claims with respect to the surgery are submitted to and processed by the plan in September. The group health plan commences a new plan year each September 1. Effective September 1, the plan sponsor elects to exempt its plan from section 2727 of the PHS Act. The plan cannot, on the basis of its exemption election, decline to pay for the claims incurred on August 24.

(ii) If a group health plan is co-sponsored by two or more employers, then only plan enrollees of the non-Federal governmental employer(s) with a valid election under this section are affected by the election.

(6) *Stop-loss or excess risk coverage.* For purposes of this section—

(i) Subject to paragraph (a)(6)(ii) of this section, the purchase of stop-loss or excess risk coverage by a self-funded non-Federal governmental plan does not prevent an election under this section.

(ii) Regardless of whether coverage offered by an issuer is designated as ''stop-loss'' coverage or ''excess risk'' coverage, if it is regulated as group health insurance under an applicable State law, then for purposes of this section, a non-Federal governmental plan that purchases the coverage is considered to be fully insured. In that event, a plan may not be exempted under this section from the requirements described in paragraph (a)(1) of this section.

(7) *Construction.* Nothing in this part should be construed as imposing collective bargaining obligations on any party to the collective bargaining process.

(b) *Form and manner of election*—(1) *Election requirements.* The election must meet the following requirements:

(i) Be made in an electronic format in a form and manner as described by the Secretary in guidance.

(ii) Be made in conformance with all of the plan sponsor's rules, including any public hearing requirements.

(iii) Specify the beginning and ending dates of the period to which the election is to apply. This period can be either of the following periods:

(A) A single specified plan year, as defined in § 144.103 of this subchapter.

(B) The ''term of the agreement,'' as specified in paragraph (b)(2) of this section, in the case of a plan governed by collective bargaining.

(iv) Specify the name of the plan and the name and address of the plan administrator, and include the name and telephone number of a person CMS may contact regarding the election.

(v) State that the plan does not include health insurance coverage, or identify which portion of the plan is not funded through health insurance coverage.

(vi) Specify each requirement described in paragraph (a)(1) of this section from which the plan sponsor elects to exempt the plan.

(vii) Certify that the person signing the election document, including (if applicable) a third party plan administrator, is legally authorized to do so by the plan sponsor.

(viii) Include, as an attachment, a copy of the notice described in paragraph (f) of this section.

(2) *''Term of the agreement'' defined.* Except as provided in paragraphs (b)(2)(i) and (ii), for purposes of this section ''term of the agreement'' means all group health plan years governed by a single collective bargaining agreement.

(i) In the case of a group health plan for which the last plan year governed by a prior collective bargaining agreement expires during the bargaining process for a new agreement, the term of the prior agreement includes all plan years governed by the agreement plus the period of time that precedes the latest of the following dates, as applicable, with respect to the new agreement:

(A) The date of an agreement between the governmental employer and union officials.

(B) The date of ratification of an agreement between the governmental employer and the union.

(C) The date impasse resolution, arbitration or other closure of the collective bargaining process is finalized when agreement is not reached.

(ii) In the case of a group health plan governed by a collective bargaining agreement for which closure is not reached before the last plan year under the immediately preceding agreement expires, the term of the new agreement includes all plan years governed by the agreement excluding the period that precedes the latest applicable date specified in paragraph (b)(2)(i) of this section.

(3) *Construction*—(i) *Dispute resolution.* Nothing in paragraph (b)(1)(ii) of this section should be construed to mean that CMS arbitrates disputes between plan sponsors, participants, beneficiaries, or their representatives regarding whether an election complies with all of a plan sponsor's rules.

(ii) *Future elections not preempted.* If a plan must comply with one or more requirements described in paragraph (a)(1) of this section for a given plan year or period of plan coverage, nothing in this section should be construed as preventing a plan sponsor from submitting an election in accordance with this section for a subsequent plan year or period of plan coverage.

(c) *Filing a timely election*—(1) *Plan not governed by collective bargaining.* Subject to paragraph (c)(4) of this section, if a plan is not governed by a collective bargaining agreement, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the plan year.

(2) *Plan governed by a collective bargaining agreement.* Subject to paragraph (d)(4) of this section, if a plan is governed by a collective bargaining agreement that was ratified before March 23, 2010, a plan sponsor or entity acting on behalf of a plan sponsor must file an election with CMS before the first day of the first plan year governed by a collective bargaining agreement, or by the 45th day after the latest applicable date specified in paragraph (b)(2)(i) of this section, if the 45th day falls on or after the first day of the plan year.

(3) *Verifying timely filing.* For elections submitted via hard copy through U.S. Mail, CMS uses the postmark on the envelope in which the election is submitted to determine that the election is timely filed as specified under paragraphs (c)(1) or (2) of this section, as applicable. If the latest filing date falls on a Saturday, Sunday, or a State or Federal holiday, CMS accepts a postmark on the next business day.

(4) *Filing extension based on good cause.* CMS may extend the deadlines specified in paragraphs (c)(1) and (2) of this section for good cause if the plan substantially complies with the requirements of paragraph (e) of this section.

(5) *Failure to file a timely election.* Absent an extension under paragraph (c)(4) of this section, a plan sponsor's failure to file a timely election under paragraph (c)(1) or (2) of this section makes the plan subject to all requirements of this part for the entire plan year to which the election would have applied, or, in the case of a plan governed by a collective bargaining agreement, for any plan years under the agreement for which the election is not timely filed.

(d) *Additional information required*—(1) *Written notification.* If an election is timely filed, but CMS determines that the election document (or the notice to plan enrollees) does not meet all of the requirements of this section, CMS may notify the plan sponsor, or other entity that filed the election, that it must submit any additional information that CMS has determined is necessary to meet those requirements. The additional information must be filed with CMS by the later of the following dates:

(i) The last day of the plan year.

(ii) The 45th day after the date of CMS's written notification requesting additional information.

(2) *Timely response.* For submissions via hard copy via U.S. Mail, CMS uses the postmark on the envelope in which the additional information is submitted to determine that the information is timely filed as specified under paragraph (d)(1) of this section. If the latest filing date falls on a Saturday, Sunday, or a State or Federal holiday, CMS accepts a postmark on the next business day.

(3) *Failure to respond timely.* CMS may invalidate an election if the plan sponsor, or other entity that filed the election, fails to timely submit the additional information as specified under paragraph (d)(1) of this section.

(e) *Notice to enrollees*—(1) *Mandatory notification.* (i) A plan that makes the election described in this section must notify each affected enrollee of the

election, and explain the consequences of the election. For purposes of this paragraph (e), if the dependent(s) of a participant reside(s) with the participant, a plan need only provide notice to the participant.

(ii) The notice must be in writing and, except as provided in paragraph (e)(2) of this section with regard to initial notices, must be provided to each enrollee at the time of enrollment under the plan, and on an annual basis no later than the last day of each plan year (as defined in § 144.103 of this subchapter) for which there is an election.

(iii) A plan may meet the notification requirements of this paragraph (e) by prominently printing the notice in a summary plan description, or equivalent description, that it provides to each enrollee at the time of enrollment, and annually. Also, when a plan provides a notice to an enrollee at the time of enrollment, that notice may serve as the initial annual notice for that enrollee.

(2) *Initial notices.* (i) If a plan is not governed by a collective bargaining agreement, with regard to the initial plan year to which an election under this section applies, the plan must provide the initial annual notice of the election to all enrollees before the first day of that plan year, and notice at the time of enrollment to all individuals who enroll during that plan year.

(ii) In the case of a collectively bargained plan, with regard to the initial plan year to which an election under this section applies, the plan must provide the initial annual notice of the election to all enrollees before the first day of the plan year, or within 30 days after the latest applicable date specified in paragraph (b)(2)(i) of this section if the 30th day falls on or after the first day of the plan year. Also, the plan must provide a notice at the time of enrollment to individuals who—

(A) Enroll on or after the first day of the plan year, when closure of the collective bargaining process is reached before the plan year begins; or

(B) Enroll on or after the latest applicable date specified in paragraph (b)(2)(i) of this section if that date falls on or after the first day of the plan year.

(3) *Notice content.* The notice must include at least the following information:

(i) The specific requirements described in paragraph (a)(1) of this section from which the plan sponsor is electing to exempt the plan, and a statement that, in general, Federal law imposes these requirements upon group health plans.

(ii) A statement that Federal law gives the plan sponsor of a self-funded non-Federal governmental plan the right to exempt the plan in whole, or in part, from the listed requirements, and that the plan sponsor has elected to do so.

(iii) A statement identifying which parts of the plan are subject to the election.

(iv) A statement identifying which of the listed requirements, if any, apply under the terms of the plan, or as required by State law, without regard to an exemption under this section.

(f) *Subsequent elections*—(1) *Election renewal.* A plan sponsor may renew an election under this section through subsequent elections. The timeliness standards described in paragraph (c) of this section apply to election renewals under this paragraph (f).

(2) *Form and manner of renewal.* Except for the requirement to forward to CMS a copy of the notice to enrollees under paragraph (b)(1)(viii) of this section, the plan sponsor must comply with the election requirements of paragraph (b)(1) of this section. In lieu of providing a copy of the notice under (b)(1)(viii), the plan sponsor may include a statement that the notice has been, or will be, provided to enrollees as specified under paragraph (e) of this section.

(3) *Election renewal includes provisions from which plan not previously exempted.* If an election renewal includes a requirement described in paragraph (a)(1) of this section from which the plan sponsor did not elect to exempt the plan for the preceding plan year, the advance notification requirements of paragraph (e)(2) of this section apply with respect to the additional requirement(s) of paragraph (a) from which the plan sponsor is electing to exempt the plan.

(4) *Special rules regarding renewal of an election under a collective bargaining agreement*—(i) If protracted negotiations with respect to a new agreement result in an extension of the term of the prior agreement (as provided under paragraph (b)(2)(i) of this section) under which an election under this section was in effect, the plan must comply with the enrollee notification requirements of paragraph (e)(1) of this section, and, following closure of the collective bargaining process, must file an election renewal with CMS as provided under paragraph (c)(2) of this section.

(ii) If a single plan applies to more than one bargaining unit, and the plan is governed by collective bargaining agreements of varying lengths, paragraph (c)(2) of this section, with respect to an election renewal, applies to the plan as governed by the agreement that results in the earliest filing date.

(g) *Requirements not subject to exemption*—(1) *Genetic information.* Without regard to an election under this section that exempts a non-Federal governmental plan from any or all of the provisions of §§ 146.111 and 146.121, the exemption election must not be construed to exempt the plan from any provisions of this part 146 that pertain to genetic information.

(2) *Enforcement.* CMS enforces these requirements as provided under paragraph (j) of this section.

(h) *Effect of failure to comply with certification and notification requirements*—(1) *Substantial failure*—(i) *General rule.* Except as provided in paragraph (h)(1)(iii) of this section, a substantial failure to comply with paragraph (e) or (g)(1) of this section results in the invalidation of an election under this section with respect to all plan enrollees for the entire plan year. That is, the plan is subject to all requirements of this part for the entire plan year to which the election otherwise would have applied.

(ii) *Determination of substantial failure.* CMS determines whether a plan has substantially failed to comply with a requirement of paragraph (e) or paragraph (g)(1) of this section based on all relevant facts and circumstances, including previous record of compliance, gravity of the violation and whether a plan corrects the failure, as warranted, within 30 days of learning of the violation. However, in general, a plan's failure to provide a notice of the fact and consequences of an election under this section to an individual at the time of enrollment, or on an annual basis before a given plan year expires, constitutes a substantial failure.

(iii) *Exceptions*—(A) *Multiple employers.* If the plan is sponsored by multiple employers, and only certain employers substantially fail to comply with the requirements of paragraph (e) or (g)(1) of this section, then the election is invalidated with respect to those employers only, and not with respect to other employers that complied with those requirements, unless the plan chooses to cancel its election entirely.

(B) *Limited failure to provide notice.* If a substantial failure to notify enrollees of the fact and consequences of an election is limited to certain individuals, the election under this section is valid only if, for the plan year with respect to which the failure has occurred, the plan agrees not to apply the election with respect to the individuals who were not notified and so informs those individuals in writing.

(2) *Examples*—(i)

Example 1. A self-funded, non-Federal group health plan is co-sponsored by 10 school districts. Nine of the school districts have fully complied with the requirements of paragraph (e) of this section, including providing notice to new employees at the time of their enrollment in the plan, regarding the group health plan's exemption under this section from requirements of this part. One school district, which hired 10 new teachers during the summer for the upcoming school year, neglected to notify three of the new hires about the group health plan's exemption election at the time they enrolled in the plan. The school district has substantially failed to comply with a requirement of paragraph (e) of this section with respect to these individuals. The school district learned of the oversight six weeks into the school year, and promptly (within 30 days of learning of the oversight) provided notice to the three teachers regarding the plan's exemption under this section and that the exemption does not apply to them, or their dependents, during the plan year of their enrollment because of the plan's failure to timely notify them of its exemption. The plan complies with the requirements of this part for these individuals for the plan year of their enrollment. CMS would not require the plan to come into compliance with the requirements of this part for other enrollees.

(ii)

Example 2. Two non-Federal governmental employers cosponsor a self-funded group health plan. One employer substantially fails to comply with the requirements of paragraph (e) of this section. While the plan may limit the invalidation of the election to enrollees of the plan sponsor that is responsible for the substantial failure, the plan sponsors determine that administering the plan in that manner would be too burdensome. Accordingly, in this example, the plan sponsors choose to cancel the election entirely. Both plan sponsors come into compliance with the requirements of this part with respect to all enrollees for the plan year for which the substantial failure has occurred.

(i) *Election invalidated.* If CMS finds cause to invalidate an election under this section, the following rules apply:

(1) CMS notifies the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) in writing that CMS has made a preliminary determination that an election is invalid, and states the basis for that determination.

(2) CMS's notice informs the plan sponsor that it has 45 days after the date of CMS's notice to explain in writing why it believes its election is valid. The plan sponsor should provide applicable statutory and regulatory citations to support its position.

(3) CMS verifies that the plan sponsor's response is timely filed as provided under paragraph (c)(3) of this section. CMS will not consider a response that is not timely filed.

(4) If CMS's preliminary determination that an election is invalid remains unchanged after CMS considers the plan sponsor's timely response (or in the event that the plan sponsor fails to respond timely), CMS provides written notice to the plan sponsor (and the plan administrator if other than the plan sponsor and the administrator's address is known to CMS) of CMS's final determination that the election is invalid. Also, CMS informs the plan sponsor that, within 45 days of the date of the notice of final determination, the plan, subject to paragraph (i)(1)(iii) of this section, must comply with all requirements of this part for the specified period for which CMS has determined the election to be invalid.

(j) *Enforcement.* To the extent that an election under this section has not been filed or a non-Federal governmental plan otherwise is subject to one or more requirements of this part, CMS enforces those requirements under part 150 of this subchapter. This may include imposing a civil money penalty against the plan or plan sponsor, as determined under subpart C of part 150.

(k) *Construction.* Nothing in this section should be construed to prevent a State from taking the following actions:

(1) Establishing, and enforcing compliance with, the requirements of State law (as defined in § 146.143(d)(1)), including requirements that parallel provisions of title XXVII of the PHS Act, that apply to non-Federal governmental plans or sponsors.

(2) Prohibiting a sponsor of a non-Federal governmental plan within the State from making an election under this section.

PART 147—HEALTH INSURANCE REFORM REQUIREMENTS FOR THE GROUP AND INDIVIDUAL HEALTH INSURANCE MARKETS

■ 4. The authority citation for part 147 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 5. Section 147.104 is amended by revising paragraph (b)(1)(i) and adding paragraph (h) to read as follows:

§ 147.104 Guaranteed availability of coverage.

* * * * *

(b) * * *

(1) * * *

(i) *Group market.* (A) Subject to paragraph (b)(1)(i)(B) of this section, a health insurance issuer in the group market must allow an employer to purchase health insurance coverage for a group health plan at any point during the year.

(B) In the case of a group health plan in the small group market that cannot comply with employer contribution or group participation rules for the offering of health insurance coverage, as allowed under applicable State law and in the case of a QHP offered in the SHOP, as permitted by § 156.1250(c) of this subchapter, a health insurance issuer may restrict the availability of coverage to an annual enrollment period that begins November 15 and extends through December 15 of each calendar year.

(C) With respect to coverage in the small group market, and in the large group market if such coverage is offered through a Small Business Health Options Program (SHOP) in a State, coverage must become effective consistent with the dates described in § 155.725(a)(2) of this subchapter, except as provided in paragraph (b)(1)(iii) of this section.

* * * * *

(h) *Construction.* Nothing in this section should be construed to require an issuer to offer coverage otherwise prohibited under applicable Federal law.

■ 6. Section 147.106 is amended by—

■ A. Revising paragraphs (c)(1) and (e).

■ B. Redesignating paragraphs (f), (g), and (h) as paragraphs (h), (i) and (j).

■ D. Adding new paragraphs (f) and (g).

The revisions and additions read as follows:

§ 147.106 Guaranteed renewability of coverage.

* * * * *

(c) * * *

(1) The issuer provides notice in writing, in a form and manner specified by the Secretary, to each plan sponsor or individual, as applicable, provided that particular product in that market (and to all participants and beneficiaries covered under such coverage) of the discontinuation at least 90 calendar days before the date the coverage will be discontinued.

* * * * *

(e) *Exception for uniform modification of coverage.* (1) Only at the time of coverage renewal may issuers modify the health insurance coverage for a product offered to a group health plan or an individual, as applicable, in the following:

(i) Large group market.

(ii) Small group market if, for coverage available in this market (other than only through one or more bona fide associations), the modification is consistent with State law and is

effective uniformly among group health plans with that product.

(iii) Individual market if the modification is consistent with State law and is effective uniformly for all individuals with that product.

(2) For purposes of this paragraph (e), modifications made solely pursuant to applicable Federal or State law are considered a uniform modification of coverage. Other types of modifications are considered a uniform modification of coverage if the product that has been modified meets all of the following criteria:

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act).

(ii) The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO)).

(iii) The product covers a majority of the same counties in its service area;

(iv) The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage described in sections 1302(d) and (e) of the Affordable Care Act.

(v) The product provides the same covered benefits, except for changes in benefits that cumulatively impact the plan-adjusted index rate for the product (as described in § 156.80(d)(2)) by no more than 2 percent (not including changes required by applicable Federal or State law).

(3) A State may establish criteria that broaden, but not restrict, the definition of a uniform modification of coverage under paragraph (e)(2) of this section.

(f) *Notice of renewal of coverage.* If an issuer is renewing coverage as described in paragraph (a) of this section, or uniformly modifying coverage as described in paragraph (e) of this section, the issuer must provide to each plan sponsor or individual, as applicable, written notice of the renewal in a form and manner specified by the Secretary.

(g) *Construction.* Nothing in this section should be construed to require an issuer to renew or continue in force coverage for which continued eligibility would otherwise be prohibited under applicable Federal law.

* * * * *

PART 148—REQUIREMENTS FOR THE INDIVIDUAL HEALTH INSURANCE MARKET

■ 7. The authority citation for part 148 continues to read as follows:

Authority: Secs. 2701 through 2763, 2791, and 2792 of the Public Health Service Act (42 U.S.C. 300gg through 300gg–63, 300gg–91, and 300gg–92), as amended.

■ 8. Section 148.101 is revised to read as follows:

§ 148.101 Basis and purpose.

This part implements sections 2741 through 2763 and 2791 and 2792 of the PHS Act. Its purpose is to guarantee the renewability of all coverage in the individual market. It also provides certain protections for mothers and newborns with respect to coverage for hospital stays in connection with childbirth and protects all individuals and family members who have, or seek, individual health insurance coverage from discrimination based on genetic information.

■ 9. Section 148.102 is revised to read as follows:

§ 148.102 Scope, applicability, and effective dates.

(a) *Scope and applicability.* (1) Individual health insurance coverage includes all health insurance coverage (as defined in § 144.103 of this subchapter) that is neither health insurance coverage sold in connection with an employment-related group health plan, nor short-term, limited-duration coverage as defined in § 144.103 of this subchapter.

(2) The requirements that pertain to guaranteed renewability for all individuals, to protections for mothers and newborns with respect to hospital stays in connection with childbirth, and to protections against discrimination based on genetic information apply to all issuers of individual health insurance coverage in the State.

(b) *Applicability date.* Except as provided in § 148.124 (certificate of creditable coverage), § 148.170 (standards relating to benefits for mothers and newborns), and § 148.180 (prohibition of health discrimination based on genetic information), the requirements of this part apply to health insurance coverage offered, sold, issued, renewed, in effect, or operated in the individual market after June 30, 1997.

§ 148.103 [Removed]

■ 10. Section 148.103 is removed.

■ 11. Section 148.120 is revised to read as follows:

§ 148.120 Guaranteed availability of individual health insurance coverage to certain individuals with prior group coverage.

The rules for guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

■ 12. Section 148.122 is amended by—

■ A. Revising paragraphs (a), (d)(1), and (g).

■ B. Redesignating paragraph (h) as paragraph (i).

■ C. Adding new paragraph (h).

The revisions and addition read as follows:

§ 148.122 Guaranteed renewability of individual health insurance coverage.

(a) *Applicability.* This section applies to non-grandfathered and grandfathered health plans (within the meaning of § 147.140 of this subchapter) that are individual health insurance coverage. *See* also § 147.106 of this subchapter for requirements relating to guaranteed renewability of coverage with respect to non-grandfathered health plans.

* * * * *

(d) * * *

(1) Provides notice in writing, in a form and manner specified by the Secretary, to each individual provided coverage of that type of health insurance at least 90 calendar days before the date the coverage will be discontinued.

* * * * *

(g) *Exception for uniform modification of coverage.* (1) An issuer may, only at the time of coverage renewal, modify the health insurance coverage for a policy form offered in the individual market if the modification is consistent with State law and is effective uniformly for all individuals with that policy form.

(2) For purposes of this paragraph (g), modifications made solely pursuant to applicable Federal or State law are considered a uniform modification of coverage. Other types of modifications are considered a uniform modification of coverage if the product that has been modified meets all of the following criteria:

(i) The product is offered by the same health insurance issuer (within the meaning of section 2791(b)(2) of the PHS Act).

(ii) The product is offered as the same product type (e.g., preferred provider organization (PPO) or health maintenance organization (HMO)).

(iii) The product covers a majority of the same counties in its service area;

(iv) The product has the same cost-sharing structure, except for variation in cost sharing solely related to changes in cost and utilization of medical care, or to maintain the same level of coverage

described in sections 1302(d) and (e) of the Affordable Care Act.

(v) The product provides the same covered benefits, except for changes in benefits that cumulatively impact the rate for the product by no more than 2 percent (not including changes required by applicable Federal or State law).

(3) A State may establish criteria that broaden, but not restrict, the definition of a uniform modification of coverage under paragraph (g)(2) of this section.

(h) *Notice of renewal of coverage.* If an issuer is renewing coverage as described in paragraph (b) of this section, or uniformly modifying coverage as described in paragraph (g) of this section, the issuer must provide to each individual written notice of the renewal in a form and manner specified by the Secretary.

* * * * *

■ 13. Section 148.124 is revised to read as follows:

§ 148.124 Certification and disclosure of coverage.

(a) *General rule.* The rules for providing certificates of creditable coverage and demonstrating creditable coverage have been superseded by the prohibition on preexisting condition exclusions. *See* § 147.108 of this subchapter for rules prohibiting the imposition of a preexisting condition exclusion.

(b) *Applicability.* The provisions of this section apply beginning December 31, 2014.

■ 14. Section 148.126 is revised to read as follows:

§ 148.126 Determination of an eligible individual.

The rules for guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

■ 15. Section 148.128 is revised to read as follows:

§ 148.128 State flexibility in individual market reforms—alternative mechanisms.

The rules for a State to implement an acceptable alternative mechanism for purposes of guaranteeing the availability of individual health insurance coverage to certain eligible individuals with prior group coverage have been superseded by the requirements of § 147.104 of this subchapter, which set forth Federal requirements for guaranteed availability of coverage in the group and individual markets.

■ 16. Section 148.220 is amended by—

■ A. Revising the introductory text.

■ B. Revising paragraph (b)(3).

■ C. Redesignating paragraphs (b)(4) through (6) as paragraphs (b)(5) through (7), respectively.

■ D. Adding new paragraph (b)(4).

The revisions and additions read as follows:

§ 148.220 Excepted benefits.

The requirements of this part and part 147 do not apply to individual health insurance coverage in relation to its provision of the benefits described in paragraphs (a) and (b) of this section (or any combination of the benefits).

* * * * *

(b) * * *

(3) Coverage only for a specified disease or illness (for example, cancer policies) if the policies meet the requirements of § 146.145(b)(4)(ii)(B) and (C) of this subchapter regarding noncoordination of benefits.

(4) Hospital indemnity or other fixed indemnity insurance only if—

(i) The benefits are provided only to individuals who have other health coverage that is minimum essential coverage within the meaning of section 5000A(f) of the Internal Revenue Code.

(ii) There is no coordination between the provision of benefits and an exclusion of benefits under any other health coverage.

(iii) The benefits are paid in a fixed dollar amount per day of hospitalization or illness or per service (for example, $100/day or $50/visit) regardless of the amount of expenses incurred and without regard to the amount of benefits provided with respect to the event or service under any other health coverage.

(iv) A notice is displayed prominently in the plan materials in at least 14 point type that has the following language: ''THIS IS A SUPPLEMENT TO HEALTH INSURANCE AND IS NOT A SUBSTITUTE FOR MAJOR MEDICAL COVERAGE. LACK OF MAJOR MEDICAL COVERAGE (OR OTHER MINIMUM ESSENTIAL COVERAGE) MAY RESULT IN AN ADDITIONAL PAYMENT WITH YOUR TAXES.''

* * * * *

PART 153—STANDARDS RELATED TO REINSURANCE, RISK CORRIDORS, AND RISK ADJUSTMENT UNDER THE AFFORDABLE CARE ACT

■ 17. The authority citation for part 153 continues to read as follows:

Authority: Secs. 1311, 1321, 1341–1343, Pub. L. 111–148, 24 Stat. 119.

■ 18. Section 153.500 is amended by revising the definition of ''adjustment percentage,'' as added on March 11, 2014 (79 FR 13835), effective on May 12, 2014, to read as follows:

§ 153.500 Definitions.

* * * * *

Adjustment percentage means, with respect to a QHP:

(1) For benefit year 2014, for a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium in a transitional State, the percentage specified by HHS for such QHPs in the transitional State; and otherwise zero percent.

(2) For benefit year 2015, for a QHP offered by a health insurance issuer in any State, two percent.

* * * * *

PART 155—EXCHANGE ESTABLISHMENT STANDARDS AND OTHER RELATED STANDARDS UNDER THE AFFORDABLE CARE ACT

■ 19. The authority citation for part 155 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301, 1302, 1303, 1304, 1311, 1312, 1313, 1321, 1322, 1331, 1332, 1334, 1402, 1411, 1412, 1413, Pub. L. 111–148, 124 Stat. 119 (42 U.S.C. 18021–18024, 18031–18033, 18041–18042, 18051, 18054, 18071, and 18081–18083).

■ 20. Section 155.120 is amended by revising paragraph (c) to read as follows:

§ 155.120 Non-interference with Federal law and non-discrimination standards.

* * * * *

(c) *Non-discrimination.* (1) In carrying out the requirements of this part, the State and the Exchange must:

(i) Comply with applicable non-discrimination statutes; and

(ii) Not discriminate based on race, color, national origin, disability, age, sex, gender identity or sexual orientation.

(2) *Exception.* Notwithstanding the provisions of paragraph (c)(1) of this section, an organization that receives Federal funds to provide services to a defined population under the terms of Federal legal authorities that participates in the certified application counselor program under § 155.225 may limit its provision of certified application counselor services to the same defined population. If the organization limits its provision of certified application counselor services pursuant to this exception, but is approached for certified application counselor services by an individual who is not included in the defined population that the organization serves, the organization must refer the

individual to other Exchange-approved resources that can provide assistance. If the organization does not limit its provision of certified application counselor services pursuant to this exception, the organization must comply with paragraph (c)(1) of this section.

■ 21. Section 155.206 is added to read as follows:

§ 155.206 Civil money penalties for violations of applicable Exchange standards by consumer assistance entities in Federally-facilitated Exchanges.

(a) *Enforcement actions.* If an individual or entity specified in paragraph (b) of this section engages in activity specified in paragraph (c) of this section, the Department of Health and Human Services (HHS) may impose the following sanctions:

(1) Civil money penalties (CMPs), subject to the provisions of this section.

(2) Corrective action plans. In the notice of assessment of CMPs specified in paragraph (l) of this section, HHS may provide an individual or entity specified in paragraph (b) of this section the opportunity to enter into a corrective action plan to correct the violation instead of paying the CMP, based on evaluation of the factors set forth in paragraph (h) of this section. In the event that the individual or entity does not follow such a corrective action plan, HHS could require payment of the CMP.

(b) *Consumer assistance entities.* CMPs may be assessed under this section against the following consumer assistance entities:

(1) Individual Navigators and Navigator entities in Federally-facilitated Exchanges, including grantees, sub-grantees, and all personnel carrying out Navigator duties on behalf of a grantee or sub-grantee;

(2) Non-Navigator assistance personnel authorized under § 155.205(d) and (e) and non-Navigator assistance personnel entities in Federally-facilitated Exchanges, including but not limited to individuals and entities under contract with HHS to facilitate consumer enrollment in QHPs in Federally-facilitated Exchanges; and

(3) Organizations that the Federally-facilitated Exchanges have designated as certified application counselor organizations and individual certified application counselors carrying out certified application counselor duties in the Federally-facilitated Exchanges.

(c) *Grounds for assessing CMPs.* HHS may assess CMPs against a consumer assistance entity if, based on the outcome of the investigative process outlined in paragraphs (d) through (i) of this section, HHS has reasonably determined that the consumer assistance entity has failed to comply with the Federally-facilitated Exchange requirements and standards applicable to the consumer assistance entity, unless a CMP has been assessed for the same conduct under 45 CFR 155.285.

(d) *Basis for initiating an investigation of a potential violation.* (1) *Information.* Any information received by HHS that indicates that a consumer assistance entity may have engaged or may be engaging in activity specified in paragraph (c) of this section may warrant an investigation. Information that might trigger an investigation includes, but is not limited to, the following:

(i) Complaints from the general public;

(ii) Reports from State regulatory agencies, and other Federal and State agencies; or

(iii) Any other information that indicates potential involvement in activity specified in paragraph (c) of this section.

(2) *Who may file a complaint.* Any entity or individual, or the legally authorized representative of an entity or individual, may file a complaint with HHS alleging that a consumer assistance entity has engaged or is engaging in an activity specified in paragraph (c) of this section.

(e) *Notice of investigation.* If HHS learns of a potential violation described in paragraph (c) of this section through the means described in paragraph (d) of this section, HHS must provide a written notice of its investigation to the consumer assistance entity. This notice must include the following:

(1) Description of the activity that is being investigated.

(2) Explanation that the consumer assistance entity has 30 days from the date of the notice to respond with additional information or documentation, including information or documentation to refute an alleged violation.

(3) State that a CMP might be assessed if the allegations are not, as determined by HHS, refuted within 30 days from the date of the notice.

(f) *Request for extension.* In circumstances in which a consumer assistance entity cannot prepare a response to HHS within the 30 days provided in the notice of investigation described in (e) of this section, the entity may make a written request for an extension from HHS detailing the reason for the extension request and showing good cause. If HHS grants the extension, the consumer assistance entity must respond to the notice within the time frame specified in HHS's letter granting the extension of time. Failure to respond within 30 days, or, if applicable, within an extended time frame, may result in HHS's imposition of a CMP depending upon the outcome of HHS's investigation of the alleged violation.

(g) *Responses to allegations of noncompliance.* In determining whether to impose a CMP, HHS may review and consider documents or information received or collected in accordance with paragraph (d)(1) of this section, as well as additional documents or information provided by the consumer assistance entity in response to receiving a notice of investigation in accordance with paragraph (e)(2) of this section. HHS may also conduct an independent investigation into the alleged violation, which may include site visits and interviews, if applicable, and may consider the results of this investigation in its determination.

(h) *Factors in determining noncompliance and CMPs, if any.* In determining whether there has been noncompliance by the consumer assistance entity, and whether CMPs are appropriate,

(1) HHS must take into account the following:

(i) The consumer assistance entity's previous or ongoing record of compliance, including but not limited to compliance or noncompliance with any corrective action plan under section (c) of this section.

(ii) The gravity of the violation, which may be determined in part by—

(A) The frequency of the violation, taking into consideration whether any violation is an isolated occurrence, represents a pattern, or is widespread; and

(B) Whether the violation caused, or could reasonably be expected to cause, financial or other adverse impacts on consumer(s), and the magnitude of those impacts;

(2) HHS may take into account the following:

(i) The degree of culpability of the consumer assistance entity, including but not limited to—

(A) Whether the violation was beyond the direct control of the consumer assistance entity; and

(B) The extent to which the consumer assistance entity received compensation—legal or otherwise—for the services associated with the violation;

(ii) Aggravating or mitigating circumstances; or

(iii) Other such factors as justice may require.

(i) *Maximum per-day penalty.* The maximum amount of penalty imposed

for each violation is $100 for each day for each consumer assistance entity for each individual directly affected by the consumer assistance entity's noncompliance; and where the number of individuals cannot be determined, the Exchange may reasonably estimate the number of individuals directly affected by the violation.

(j) *Settlement authority.* Nothing in § 155.206 limits the authority of HHS to settle any issue or case described in the notice furnished in accordance with paragraph (e) or to compromise on any penalty provided for in this section.

(k) *Limitations on penalties.* (1) *Circumstances under which a civil money penalty is not imposed.* HHS will not impose any civil money penalty on:

(i) Any violation for the period of time during which none of the consumer assistance entities knew, or exercising reasonable diligence would have known, of the violation; or

(ii) The period of time after any of the consumer assistance entities knew, or exercising reasonable diligence would have known, of the failure, if the violation was due to reasonable cause and not due to willful neglect and the violation was corrected within 30 days of the first day that any of the consumer assistance entities against whom the penalty would be imposed knew, or exercising reasonable diligence would have known, that the violation existed.

(2) *Burden of establishing knowledge.* The burden is on the consumer assistance entity or entities to establish to HHS's satisfaction that the consumer assistance entity did not know, or exercising reasonable diligence would have known, that the violation existed, as well as the period of time during which that limitation applies; or that the violation was due to reasonable cause and not due to willful neglect and was corrected pursuant to the elements in subparagraph (k)(1)(ii).

(l) *Notice of assessment of CMP.* If HHS proposes to assess a CMP in accordance with this section, HHS will send a written notice of this decision to—

(1) The consumer assistance entity against whom the sanction is being imposed, which notice must include the following:

(i) A description of the basis for the determination;

(ii) The basis for the CMP;

(iii) The amount of the CMP, if applicable;

(iv) The date the CMP, if applicable, is due;

(v) Whether HHS would permit the consumer assistance entity to enter into a corrective action plan in place of paying the CMP, and the terms of any such corrective action plan;

(vi) An explanation of the consumer assistance entity's right to a hearing under paragraph (m) of this section; and

(vii) Information about the process for filing a request for a hearing.

(m) *Appeal of proposed sanction.* Any consumer assistance entity against which HHS has assessed a sanction may appeal that penalty in accordance with the procedures set forth at 45 CFR Part 150, Subpart D.

(n) *Failure to request a hearing.* (1) If the consumer assistance entity does not request a hearing within 30 days of the issuance of the notice of assessment of CMP described in paragraph (l) of this section, HHS may require payment of the proposed CMP.

(2) HHS will notify the consumer assistance entity in writing of any CMP that has been assessed and of the means by which the consumer assistance entity may pay the CMP.

(3) The consumer assistance entity has no right to appeal a CMP with respect to which it has not requested a hearing in accordance with paragraph (m) of this section unless the consumer assistance entity can show good cause in accordance with § 150.405(b) of this subchapter for failing to timely exercise its right to a hearing.

■ 22. Section 155.210 is amended—

■ A. By revising paragraph (c)(1)(iii).

■ B. In paragraph (d)(3) by removing ''or,'' after the semicolon.

■ C. In paragraph (d)(4) by removing the period at the end of the paragraph and adding a semicolon in its place.

■ D. By adding paragraphs (d)(5) through (9) and (e)(6) and (7).

The revision and additions read as follows:

§ 155.210 Navigator program standards.

(c) * * *

(1) * * *

(iii) Meet any licensing, certification or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not limited to the following:

(A) Except as otherwise provided under § 155.705(d), requirements that Navigators refer consumers to other entities not required to provide fair, accurate, and impartial information.

(B) Except as otherwise provided under § 155.705(d), requirements that would prevent Navigators from providing services to all persons to whom they are required to provide assistance.

(C) Requirements that would prevent Navigators from providing advice regarding substantive benefits or comparative benefits of different health plans.

(D) Requiring that a Navigator hold an agent or broker license or carry errors or omissions insurance.

(E) In a Federally-facilitated Exchange, imposing standards that would prohibit individuals or entities from acting as Navigators that would be eligible to participate as Navigators under standards applicable to the Federally-facilitated Exchange.

(F) In a Federally-facilitated Exchange, imposing standards that would, as applied or as implemented in a State, prevent the application of requirements applicable to the Federally-facilitated Exchange.

* * * * *

(d) * * *

(5) Charge any applicant or enrollee, or request or receive any form of remuneration from or on behalf of an individual applicant or enrollee, for application or other assistance related to Navigator duties; or

(6) Provide compensation to individual Navigators on a per-application, per-individual-assisted, or per-enrollment basis.

(7) Provide gifts, including gift cards or cash, unless they are of nominal value, or provide promotional items that market or promote the products or services of a third party, to any applicant or potential enrollee in connection with or as an inducement for application assistance or enrollment.

(8) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact.

(9) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice.

(e) * * *

(6) Ensure that applicants—

(i) Are informed of the functions and responsibilities of Navigators;

(ii) Provide authorization in a form and manner as determined by the Secretary prior to a Navigator's obtaining access to an applicant's personally identifiable information, and that the Navigator maintains a record of the authorization provided. The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is three years,

unless a different retention period has already been provided under 45 CFR 92.42 and 45 CFR 74.53 or other applicable Federal law; and

(iii) May revoke at any time the authorization provided the Navigator pursuant to paragraph (e)(6)(ii) of this section.

(7) Maintain a physical presence in the Exchange service area, so that face-to-face assistance can be provided to applicants and enrollees.

* * * * *

■ 23. Section 155.215 is amended by adding paragraphs (f) and (g) to read as follows:

§ 155.215 Standards applicable to Navigators and Non-Navigator Assistance Personnel carrying out consumer assistance functions under §§ 155.205(d) and (e) and 155.210 in a Federally-facilitated Exchange and to Non-Navigator Assistance Personnel funded through an Exchange Establishment Grant.

* * * * *

(f) *State or Exchange standards.* All non-Navigator entities or individuals carrying out consumer assistance functions under § 155.205(d) and (e) must comply with the eligibility standard set forth under § 155.210(c)(1)(iii), except for § 155.210(c)(1)(iii)(D).

(g) *Consumer authorization.* All non-Navigator entities or individuals carrying out consumer assistance functions under § 155.205(d) and (e) must establish procedures to ensure that applicants—

(1) Are informed of the functions and responsibilities of non-Navigator assistance personnel;

(2) Provide authorization in a form and manner as determined by the Secretary prior to a non-Navigator assistance personnel's obtaining access to an applicant's personally identifiable information, and that the non-Navigator assistance personnel maintains a record of the authorization provided. The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is three years, unless an different retention period has already been provided in applicable Federal law; and

(3) May revoke at any time the authorization provided the non-Navigator assistance personnel pursuant to paragraph (g)(2) of this section.

■ 24. Section 155.225 is amended—

■ A. In paragraph (b)(1)(i) by removing ''and'' after the semicolon.

■ B. In paragraph (b)(1)(ii) by removing the period at the end of the paragraph and adding ''; and'' in its place.

■ C. By adding paragraph (b)(1)(iii).

■ D. In paragraph (d)(5) by removing ''and'' after the semicolon.

■ E. In paragraph (d)(6) by removing the period at the end of the paragraph and adding a semicolon in its place.

■ F. By adding paragraphs (d)(7) and (8).

■ G. By revising paragraphs (f)(1) and (2) and (g).

The revisions and additions read as follows:

§ 155.225 Certified application counselors.

* * * * *

(b) * * *

(1) * * *

(iii) Maintain a physical presence in the Exchange service area, so that face-to-face assistance can be provided to applicants and enrollees.

* * * * *

(d) * * *

(7) Is recertified on at least an annual basis after successfully completing recertification training as required by the Exchange; and

(8) Meets any licensing, certification, or other standards prescribed by the State or Exchange, if applicable, so long as such standards do not prevent the application of the provisions of title I of the Affordable Care Act. Standards that would prevent the application of the provisions of title I of the Affordable Care Act include but are not limited to the following:

(i) Requirements that certified application counselors refer consumers to other entities not required to act in the best interest of applicants assisted.

(ii) Requirements that would prevent certified application counselors from providing services to all persons to whom they are required to provide assistance.

(iii) Requirements that would prevent certified application counselors from providing advice regarding substantive benefits or comparative benefits of different health plans.

(iv) In a Federally-facilitated Exchange, imposing standards that would prohibit individuals or entities from acting as certified application counselors that would be eligible to participate as certified application counselors under standards applicable to the Federally-facilitated Exchange.

(v) In a Federally-facilitated Exchange, imposing standards that would, as applied or as implemented in a State, prevent the application of requirements applicable to the Federally-facilitated Exchange.

* * * * *

(f) * * *

(1) Are informed of the functions and responsibilities of certified application counselors;

(2) Provide authorization prior to a certified application counselor obtaining access to an applicant's personally identifiable information and that the organization or certified application counselor maintains a record of the authorization. The Exchange must establish a reasonable retention period for maintaining these records. In Federally-facilitated Exchanges, this period is three years, unless a different retention period has already been provided under other applicable Federal law; and

* * * * *

(g) *Fees, consideration, solicitation, and marketing.* Organizations designated by the Exchange under paragraph (b) of this section and certified application counselors must not—

(1) Impose any charge on applicants or enrollees for application or other assistance related to the Exchange;

(2) Receive any consideration directly or indirectly from any health insurance issuer or issuer of stop-loss insurance in connection with the enrollment of any individuals in a QHP or a non-QHP;

(3) Provide compensation to individual certified application counselors on a per-application, per-individual- assisted, or per-enrollment basis;

(4) Provide gifts, including gift cards or cash, unless they are of nominal value, or provide promotional items that market or promote the products or services of a third party, to any applicant or potential enrollee in connection with or as an inducement for application assistance or enrollment;

(5) Solicit any consumer for application or enrollment assistance by going door-to-door or through other unsolicited means of direct contact, including calling a consumer to provide application or enrollment assistance without the consumer initiating the contact; or

(6) Initiate any telephone call to a consumer using an automatic telephone dialing system or an artificial or prerecorded voice.

■ 25. Section 155.240 is amended by adding paragraph (e) to read as follows:

§ 155.240 Payment of premium.

* * * * *

(e) *Premium calculation.* The Exchange may establish one or more standard processes for premium calculation.

(1) For a Federally-facilitated Exchange, the premium for coverage lasting less than one month must equal the product of—

(i) The premium for one month of coverage divided by the number of days in the month; and

(ii) The number of days for which coverage is being provided in the month described in paragraph (e)(1)(i) of this section.

(2) [Reserved]

■ 26. Section 156.260 is amended by revising paragraph (g) to read as follows:

§ 155.260 Privacy and security of personally identifiable information.

* * * * *

(g) *Improper use and disclosure of information.* Any person who knowingly and willfully uses or discloses information in violation of section 1411(g) of the Affordable Care Act will be subject to a CMP of not more than the maximum amount specified in section 1411(h)(2) of the Affordable Care Act per person or entity, per use or disclosure, consistent with the bases and process for imposing civil penalties specified at § 155.285 of this subpart, in addition to other penalties that may be prescribed by law.

■ 27. Section 155.285 is added to subpart C to read as follows:

§ 155.285 Bases and process for imposing civil penalties for provision of false or fraudulent information to an Exchange or improper use or disclosure of information.

(a) *Grounds for imposing civil money penalties.* (1) HHS may impose civil money penalties on any person, as defined in paragraph (a)(2) of this section, if, based on credible evidence, HHS reasonably determines that a person has engaged in one or more of the following actions:

(i) Failure to provide correct information under section 1411(b) of the Affordable Care Act where such failure is attributable to negligence or disregard of any rules or regulations of the Secretary with negligence and disregard defined as they are in section 6662 of the Internal Revenue Code of 1986:

(A) ''Negligence'' includes any failure to make a reasonable attempt to provide accurate, complete, and comprehensive information; and

(B) ''Disregard'' includes any careless, reckless, or intentional disregard for any rules or regulations of the Secretary.

(ii) Knowing and willful provision of false or fraudulent information required under section 1411(b) of the Affordable Care Act, where knowing and willful means the intentional provision of information that the person knows to be false; or

(iii) Knowing and willful use or disclosure of information in violation of section 1411(g) of the Affordable Care Act, where knowing and willful means the intentional use or disclosure of information in violation of section 1411(g). Such violations would include, but not be limited to, the following:

(A) Any use or disclosure performed which violates relevant privacy and security standards established by the Exchange pursuant to § 155.260;

(B) Any other use or disclosure which has not been determined by the Secretary to be in compliance with section 1411(g)(2)(A) of the Affordable Care Act pursuant to § 155.260(a); and

(C) Any other use or disclosure which is not necessary to carry out a function described in a contract with a non-Exchange entity executed pursuant to § 155.260(b)(2).

(2) For purposes of this section, the term ''person'' is defined to include, but is not limited to, all individuals; corporations; Exchanges; Medicaid and CHIP agencies; other entities gaining access to personally identifiable information submitted to an Exchange to carry out additional functions which the Secretary has determined ensure the efficient operation of the Exchange pursuant to § 155.260(a)(1); and non-Exchange entities as defined in § 155.260(b) which includes agents, brokers, Web-brokers, QHP issuers, Navigators, non-Navigator assistance personnel; certified application counselors, in-person assistors, and other third party contractors.

(b) *Factors in determining the amount of civil money penalties imposed.* In determining the amount of civil money penalties, HHS may take into account factors which include, but are not limited to, the following:

(1) The nature and circumstances of the conduct including:

(i) The number of violations;

(ii) The severity of the violations;

(iii) The person's history with the Exchange including any prior violations that would indicate whether the violation is an isolated occurrence or represents a pattern of behavior;

(iv) The length of time of the violation;

(v) The number of individuals affected or potentially affected;

(vi) The extent to which the person received compensation or other consideration associated with the violation; and

(vii) Any documentation provided in any complaint or other information, as well as any additional information provided by the individual to refute performing the violation.

(2) The nature of the harm resulting from, or reasonably expected to result from, the violation including:

(i) Whether the violation resulted in financial harm;

(ii) Whether there was harm to an individual's reputation;

(iii) Whether the violation hindered or could have hindered an individual's ability to obtain health insurance coverage;

(v) The actual or potential impact of the provision of false or fraudulent information or of the improper use or disclosure of the information; and

(vi) Whether any person received a more favorable eligibility determination for enrollment in a QHP or insurance affordability program, such as greater advance payment of the premium tax credits or cost-sharing reductions than he or she would be eligible for if the correct information had been provided.

(3) No penalty will be imposed under paragraph (a)(1)(i) of this section if HHS determines that there was a reasonable cause for the failure to provide correct information required under section 1411(b) of the Affordable Care Act and that the person acted in good faith.

(c) *Maximum penalty.* The amount of a civil money penalty will be determined by HHS in accordance with paragraph (b) of this section.

(1) The following provisions provide maximum penalties for a single ''plan year,'' where ''plan year'' has the same meaning as at § 155.20 of this part:

(i) Any person who fails to provide correct information as specified in paragraph (a)(1)(i) of this section may be subject to a maximum civil money penalty as specified in section 1411(h)(1)(A)(i) of the Affordable Care Act for each application, as defined at paragraph (c)(1)(iii) of this section, pursuant to which a person fails to provide correct information.

(ii) Any person who knowingly and willfully provides false information as specified in paragraph (a)(1)(ii) of this section may be subject to a maximum civil money penalty as specified in section 1411(h)(1)(B) of the Affordable Care Act for each application, as defined at paragraph (c)(1)(iii) of this section, on which a person knowingly and willfully provides false information.

(iii) For the purposes of this subsection, ''application'' is defined as a submission of information, whether through an online portal, over the telephone through a call center, or through a paper submission process, in which the information is provided in relation to an eligibility determination; an eligibility redetermination based on a change in an individual's circumstances; or an annual eligibility redetermination for any of the following:

(A) Enrollment in a qualified health plan;

(B) Premium tax credits or cost sharing reductions; or

(C) An exemption from the individual shared responsibility payment.

(2) Any person who knowingly or willfully uses or discloses information as specified in paragraph (a)(1)(iii) of this section may be subject to the following civil money penalty:

(i) A civil money penalty for each use or disclosure described in paragraph (a)(1)(iii) of this section of not more than the maximum amount specified in section 1411(h)(2) of the Affordable Care Act per use or disclosure.

(ii) For purposes of this subsection, a use or disclosure includes one separate use or disclosure of a single individual's personally identifiable information where the person against whom a civil money penalty may be imposed has made the use or disclosure.

(3) These penalties may be imposed in addition to any other penalties that may be prescribed by law.

(d) *Notice of intent to issue civil money penalty.* If HHS intends to impose a civil money penalty in accordance with this part, HHS will send a written notice of such intent to the person against whom it intends to impose a civil money penalty.

(1) This written notice will be either hand delivered, sent by certified mail, return receipt requested, or sent by overnight delivery service with signature upon delivery required. The written notice must include the following elements:

(i) A description of the findings of fact regarding the violations with respect to which the civil money penalty is proposed;

(ii) The basis and reasons why the findings of fact subject the person to a penalty;

(iii) Any circumstances described in paragraph (b) of this section that were considered in determining the amount of the proposed penalty;

(iv) The amount of the proposed penalty;

(v) An explanation of the person's right to a hearing under any applicable administrative hearing process;

(vi) A statement that failure to request a hearing within 60 calendar days after the date of issuance printed on the notice permits the assessment of the proposed penalty; and

(vii) Information explaining how to file a request for a hearing and the address to which the hearing request must be sent.

(2) The person may request a hearing before an ALJ on the proposed penalty by filing a request in accordance with the procedure to file a request specified in the notice of intent to issue a civil money penalty.

(e) *Failure to request a hearing.* If the person does not request a hearing within 60 calendar days of the date of issuance printed on the notice described in paragraph (d) of this section, HHS may impose the proposed civil money penalty.

(1) HHS will notify the person in writing of any penalty that has been imposed, the means by which the person may satisfy the penalty, and the date on which the penalty is due.

(2) A person has no right to appeal a penalty with respect to which the person has not timely requested a hearing in accordance with paragraph (d) of this section.

(f) *Appeal of proposed penalty.* Subject to paragraph (e)(2) of this section, any person against whom HHS has imposed a civil money penalty may appeal that penalty in accordance with the rules and procedures outlined at 45 CFR part 150, subpart D, excluding §§ 150.461, 150.463, and 150.465.

(g) *Enforcement authority.* (1) *CMS.* CMS may impose civil money penalties up to the maximum amounts specified in paragraph (d) of this section for any of the violations described in paragraph (a) of this section.

(2) *OIG.* In accordance with the rules and procedures of 42 CFR part 1003, and in place of imposition of penalties by CMS, the OIG may impose civil money penalties for violations described in paragraphs (a)(1)(ii) and (iii) of this section.

(h) *Settlement authority.* Nothing in this section limits the authority of CMS to settle any issue or case described in the notice furnished in accordance with § 155.285(d) or to compromise on any penalty provided for in this section.

(i) *Limitations.* No action under this section will be entertained unless commenced, in accordance with § 155.285(d), within 6 years from the date on which the violation occurred.

■ 28. Section 155.320 is amended by revising the section heading and removing paragraph (d)(4).

The revision reads as follows:

§ 155.320 Verification process related to eligibility for insurance affordability programs.

* * * * *

■ 29. Section 155.330 is amended by revising paragraph (d)(2)(ii) to read as follows:

§ 155.330 Eligibility redetermination during a benefit year.

* * * * *

(d) * * *

(2) * * *

(ii) Comply with the standards specified in paragraph (e)(2) of this section.

* * * * *

■ 30. Section 155.400 is amended by adding paragraphs (e) and (f) to read as follows:

§ 155.400 Enrollment of qualified individuals into QHPs.

* * * * *

(e) *Premium payment.* Exchanges may, and the Federally-facilitated Exchange will, require payment of the first month's premium to effectuate an enrollment.

(f) *Processing enrollment transactions.* The Exchange may provide requirements to QHP issuers regarding the instructions for processing electronic enrollment-related transactions.

■ 31. Section 155.420 is amended by revising paragraphs (b)(2)(i) through (iii), (c), (d)(1), (d)(6)(iii), and (e) introductory text to read as follows:

§ 155.420 Special enrollment periods.

* * * * *

(b) * * *

(2) * * *

(i) In the case of birth, adoption, placement for adoption, or placement in foster care, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the date of birth, adoption, placement for adoption, or placement in foster care, but may permit the qualified individual or enrollee to elect a later coverage effective date. If the Exchange permits the qualified individual or enrollee to elect a later coverage effective date, the Exchange must ensure coverage is effective on the date elected by the qualified individual or enrollee.

(ii) In the case of marriage, or in the case where a qualified individual loses minimum essential coverage or other coverage, as described in paragraph (d)(1) of this section, the Exchange must ensure that coverage is effective for a qualified individual or enrollee on the first day of the following month.

(iii) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9), or (d)(10) of this section, the Exchange must ensure that coverage is effective on an appropriate date based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS.

* * * * *

(c) *Availability and length of special enrollment periods.* (1) Unless specifically stated otherwise herein, a qualified individual or enrollee has 60

days from the date of a triggering event to select a QHP;

(2) A qualified individual or enrollee whose coverage specified in paragraph (d)(1) or whose eligibility for qualifying coverage in an eligible-employer sponsored plan as specified in paragraph (d)(6)(iii) of this section will end within the next 60 days has 120 days from the date that is 60 days prior to the end of such coverage or eligibility to select a QHP, including prior to the end of his or her existing coverage or eligibility for qualifying coverage in an eligible-employer sponsored plan as specified in paragraph (d)(6)(iii) of this section, although he or she is not eligible for advance payments of the premium tax credit until the end of his or her existing coverage or eligibility for qualifying coverage in an eligible-employer sponsored plan as specified in paragraph (d)(6)(iii) of this section;

(3) In the case of a qualified individual or enrollee eligible for a special enrollment period as described in paragraphs (d)(4), (d)(5), (d)(9), or (d)(10) of this section, the Exchange may define the length of this special enrollment period as appropriate based on the circumstances of the special enrollment period, in accordance with guidelines issued by HHS.

(d) * * *

(1) The qualified individual or his or her dependent loses minimum essential coverage, is enrolled in any non-calendar year individual health insurance policy as described in § 147.104(b)(2) of this subchapter, even if the qualified individual or his her or dependent has the option to renew the expiring non-calendar year individual health insurance policy, or loses pregnancy-related coverage described under section 1902(a)(10)(A)(i)(IV) and (a)(10)(A)(ii)(IX) of the Social Security Act (42 U.S.C. 1396a(a)(10)(A)(i)(IV), (a)(10)(A)(ii)(IX)).

* * * * *

(6) * * *

(iii) A qualified individual or his or her dependent who is enrolled in an eligible employer-sponsored plan is determined newly eligible for advance payments of the premium tax credit based in part on a finding that such individual is ineligible for qualifying coverage in an eligible-employer sponsored plan in accordance with 26 CFR 1.36B–2(c)(3), including as a result of his or her employer discontinuing or changing available coverage within the next 60 days, provided that such individual is allowed to terminate existing coverage.

* * * * *

(e) *Loss of coverage.* Loss of minimum essential coverage or other coverage described in paragraph (d)(1) of this section includes those circumstances described in 26 CFR 54.9801–6(a)(3)(i) through (iii). Loss of coverage does not include voluntary termination or loss due to—

* * * * *

■ 32. Section 155.430 is amended by revising paragraph (d)(6) and adding paragraph (e) to read as follows:

§ 155.430 Termination of coverage.

* * * * *

(d) * * *

(6) In the case of a termination in accordance with paragraph (b)(2)(v) of this section, the last day of coverage in an enrollee's prior QHP is the day before the effective date of coverage in his or her new QHP, including any retroactive enrollments effectuated under § 155.420(b)(2)(iii). In cases of retroactive terminations dates, the Exchange will ensure that appropriate actions are taken to make necessary adjustments to advance payments of the premium tax credit, cost-sharing reductions, premiums, and claims.

* * * * *

(e) *Termination, cancellation, and reinstatement.* The Exchange may establish operational instructions as to the form, manner, and method for addressing each of the following:

(1) *Termination.* A termination is an action taken after a coverage effective date that ends an enrollee's coverage through the Exchange for a date after the original coverage effective date, resulting in a period during which the individual was covered by the issuer.

(2) *Cancellation.* A cancellation is specific type of termination action that ends a qualified individuals' enrollment on the date coverage became effective resulting in coverage never having been effective with the QHP.

(3) *Reinstatement.* A reinstatement is a correction of an erroneous termination or cancellation action and results in restoration of an enrollment with no break in coverage.

§ 155.505 [Amended].

■ 33. Section 155.505 is amended in paragraph (b)(4) by removing ''; and'' at the end of the paragraph and adding a period in its place.

■ 34. Section 155.530 is amended by revising paragraph (a)(1) to read as follows:

§ 155.530 Dismissals.

(a) * * *

(1) Withdraws the appeal request in writing or by telephone, if the appeals entity is capable of accepting telephonic withdrawals.

(i) Accepting telephonic withdrawals means the appeals entity—

(A) Records in full the appellant's statement and telephonic signature made under penalty of perjury; and

(B) Provides a written confirmation to the appellant documenting the telephonic interaction.

(ii) [Reserved]

* * * * *

■ 35. Section 155.555 is amended by—

■ A. Redesignating paragraphs (d) introductory text, (d)(1), (d)(2) introductory text, (d)(2)(i), (ii), (iii), (d)(3), and (d)(4) as paragraphs (d)(1) introductory text, (d)(1)(i), (d)(1)(ii) introductory text, (d)(1)(ii)(A), (B), (C), (d)(1)(iii), and (d)(2).

■ B. Revising new paragraph (d)(2) introductory text.

The revision reads as follows:

§ 155.555 Employer appeals process.

* * * * *

(d) * * *

(2) Upon receipt of an invalid appeal request, the appeals entity must promptly and without undue delay send written notice to the employer that the appeal request is not valid because it fails to meet the requirements of this section. The written notice must inform the employer—

* * * * *

■ 36. Section 155.625 is revised to read as follows:

§ 155.625 Options for conducting eligibility determinations for exemptions.

(a) *Options for conducting eligibility determinations.* The Exchange may satisfy the requirements of this subpart—

(1) Directly or through contracting arrangements in accordance with § 155.110(a); or

(2) For an application submitted before November 15, 2014, through the approach described in paragraph (b) of this section.

(b) *Use of HHS service.* Notwithstanding the requirements of this subpart, for an application submitted before November 15, 2014, the Exchange may adopt an exemption eligibility determination made by HHS, provided that—

(1) The Exchange adheres to the eligibility determination made by HHS;

(2) The Exchange furnishes to HHS any information available through the Exchange that is necessary for an applicant to utilize the process administered by HHS; and

(3) The Exchange call center and Internet Web site specified in § 155.205(a) and (b), respectively,

provide information to consumers regarding the exemption eligibility process.

■ 37. Section 155.705, as amended March 11, 2014 (79 FR 13838), and effective May 12, 2014, is amended by—

■ A. Revising paragraphs (b)(2) and (b)(3)(ii) introductory text and (b)(3)(iv) introductory text.

■ B. Adding paragraph (b)(3)(vi).

The revisions and addition read as follows:

§ 155.705 Functions of a SHOP.

* * * * *

(b) * * *

(2) *Employer choice requirements.* With regard to QHPs offered through the SHOP for plan years beginning on or after January 1, 2015, the SHOP must allow a qualified employer to select a level of coverage as described in section 1302(d)(1) of the Affordable Care Act, in which all QHPs within that level are made available to the qualified employees of the employer, unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section.

(3) * * *

(ii) Unless the SHOP makes an election pursuant to paragraph (b)(3)(vi) of this section, for plan years beginning on or after January 1, 2015, a SHOP:

* * * * *

(iv) Unless the Secretary makes an election pursuant to paragraph (b)(3)(vi) of this section, for plan years beginning on or after January 1, 2015, a Federally-facilitated SHOP will provide a qualified employer a choice of two methods to make QHPs available to qualified employees:

* * * * *

(vi) For plan years beginning in 2015, the SHOP may, based on the recommendation of a State regulatory agency, elect to provide employers only with the options set forth at paragraph (b)(3)(ii)(B) or in the case of a Federally-facilitated SHOP, only with the option set forth at paragraph (b)(3)(iv)(B) of this section, only if:

(A) The implementation of paragraphs (b)(3)(ii)(A) or (b)(3)(iv)(A) of this section would result in significant adverse selection in the State's small group market resulting in market disruptions that could not be remediated by sections 1312(c), 1342, and 1343 of the Affordable Care Act (relating to single risk pool, risk corridors, and risk adjustment); or

(B) There are insufficient issuers of qualified health plans or qualified stand-alone dental plans in the SHOP to allow for meaningful choice among qualified health plans or qualified stand-alone dental plans for all levels of coverage as described in section 1302(d)(1) of the Affordable Care Act.

* * * * *

■ 38. Section 155.725 is amended by revising paragraphs (c) and (e) to read as follows:

§ 155.725 Enrollment periods under SHOP.

* * * * *

(c) *Annual employer election period.* (1) Notwithstanding any other paragraph in this section, for coverage beginning in 2015, a qualified employer's annual election period may begin no sooner than November 15, 2014.

(2) The SHOP must provide qualified employers with a standard election period prior to the completion of the employer's plan year and before the annual employee open enrollment period, in which the qualified employer may change its participation in the SHOP for the next plan year, including—

(i) The method by which the qualified employer makes QHPs available to qualified employees pursuant to § 155.705(b)(2) and (3);

(ii) The employer contribution towards the premium cost of coverage;

(iii) The level of coverage offered to qualified employees as described in § 155.705(b)(2) and (3); and

(iv) The QHP or QHPs offered to qualified employees in accordance with § 155.705.

* * * * *

(e) *Annual employee open enrollment period.* The SHOP must establish a standardized annual open enrollment period for qualified employees prior to the completion of the applicable qualified employer's plan year and after that employer's annual election period.

* * * * *

■ 39. Section 155.740 is amended by—

■ A. Redesignating paragraphs (g) introductory text, (g)(1) introductory text, (g)(1)(i), (g)(1)(ii), (g)(2), and (g)(3) as paragraphs (g)(1)(i) introductory text, (g)(1)(i)(A), (g)(1)(i)(B), (g)(1)(ii), and (g)(2).

■ B. Revising paragraph (i)(1)(i).

The revision read as follows:

§ 155.740 SHOP employer and employee eligibility appeals requirements.

* * * * *

(i) * * *

(1) * * *

(i) Withdraws the request in accordance with the standards set forth in § 155.530(a)(1); or

* * * * *

■ 40. Subpart O is added to read as follows:

Subpart O—Quality Reporting Standards for Exchanges

Sec.

155.1400 Quality rating system.

155.1405 Enrollee satisfaction survey system.

Subpart O—Quality Reporting Standards for Exchanges

§ 155.1400 Quality rating system.

The Exchange must prominently display the quality rating information assigned to each QHP on its Web site, in accordance with § 155.205(b)(1)(v), as calculated by HHS and in a form and manner specified by HHS.

§ 155.1405 Enrollee satisfaction survey system.

The Exchange must prominently display results from the Enrollee Satisfaction Survey for each QHP on its Web site, in accordance with § 155.205(b)(1)(iv), as calculated by HHS and in a form and manner specified by HHS.

PART 156—HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

■ 41. The authority citation for part 156 continues to read as follows:

Authority: Title I of the Affordable Care Act, sections 1301–1304, 1311–1313, 1321–1322, 1324, 1334, 1342–1343, 1401–1402, Pub. L. 111–148, 124 Stat. 119 42 U.S.C. 18021–18024, 18031–18032, 18041–18042, 18044, 18054, 18061, 18063, 18071, 18082, 26 U.S.C. 36B, and 31 U.S.C. 9701).

■ 42. Section 156.130 is amended by revising paragraph (d) to read as follows:

§ 156.130 Cost-sharing requirements.

* * * * *

(d) *Increase annual dollar limits in multiples of 50.* For a plan year beginning in a calendar year after 2014, any increase in the annual dollar limits described in paragraphs (a) and (b) of this section that does not result in a multiple of 50 dollars will be rounded down, to the next lowest multiple of 50 dollars.

* * * * *

■ 43. Section 156.200 is amended by revising paragraph (b)(5) and adding paragraph (h) to read as follows:

§ 156.200 QHP issuer participation standards.

* * * * *

(b) * * *

(5) Implement and report on a quality improvement strategy or strategies described in section 1311(c)(1)(E) of the Affordable Care Act consistent with the

standards of section 1311(g) of the Affordable Care Act, disclose and report information on health care quality and outcomes described in sections 1311(c)(1)(H), (c)(1)(I), and (c)(3) of the Affordable Care Act, and implement appropriate enrollee satisfaction surveys consistent with section 1311(c)(4) of the Affordable Care Act;

* * * * *

(h) *Operational requirements.* As a condition of certification of a QHP, an issuer must attest that it will comply with all QHP operational requirements described in Subparts D, E, H, K, L and M of this part.

■ 44. Section 156.265 is amended by revising paragraph (d) to read as follows:

§ 156.265 Enrollment process for qualified individuals.

* * * * *

(d) *Premium payment.* A QHP issuer—

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

(2) Must, for QHPs offered through a Federally-facilitated Exchange, establish the date by which a qualified individual that has selected a QHP within the enrollment period dates in § 155.410(b) of this subchapter must make a premium payment in order to effectuate coverage by the applicable coverage date, provided that:

(i) The payment date is no later than the day before the coverage effective date.

(ii) The payment date policy is applied consistently to all applicants in a non-discriminatory manner.

* * * * *

■ 45. Section 156.602 is amended by redesignating paragraph (e) as paragraph (f) and adding a new paragraph (e) to read as follows:

§ 156.602 Other coverage that qualifies as minimum essential coverage.

* * * * *

(e) *Foreign group health coverage.* (1) *Foreign group health coverage for expatriates.* The following types of foreign group health coverage will be recognized as minimum essential coverage for expatriates:

(i) Group health coverage for citizens or nationals of the United States working abroad, provided by either of the following:

(A) A foreign, self-insured group health plan.

(B) Health insurance regulated by a foreign government or health coverage provided by a foreign national health plan with respect to a citizen or national of the United States who, for such month, is physically absent from the United States for at least one day of the month, or who is physically present in the United States for an entire month if the coverage provides health benefits within the United States.

(ii) Group health coverage for non-United States citizens or nationals residing in the United States, provided by a self-insured group health plan, health insurance regulated by a foreign government, or health coverage provided by a foreign national health plan, if the coverage provides health benefits within the United States.

(2) *Notice.* The sponsor, issuer, or plan administrator of foreign group health coverage as described in this paragraph (e) must provide notice to enrollees who are citizens or nationals of the United States of its minimum essential coverage status and must comply, if applicable, with the information and reporting requirements of section 6055 of the Code and implementing regulations with respect to those enrollees.

(3) *Definition of expatriate.* For purposes of this section, an expatriate means an individual for whom there is a good faith expectation that such individual will reside outside of their home country or outside of the United States for at least six months of a 12-month period and any covered dependents.

* * * * *

■ 46. Section 156.604 is amended by revising paragraphs (a)(2) introductory text and (d) to read as follows:

§ 156.604 Requirements for recognition as minimum essential coverage for types of coverage not otherwise designated minimum essential coverage in the statute or this subpart.

(a) * * *

(2) *Procedural requirements for recognition as minimum essential coverage.* To be considered for recognition as minimum essential coverage, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator must submit the following information to HHS:

* * * * *

(d) *Notice.* Once recognized as minimum essential coverage, the sponsor of the coverage, government agency, health insurance issuer, or plan administrator must provide notice to all enrollees of its minimum essential coverage status and must comply with the information reporting requirements of section 6055 of the Code and implementing regulations.

■ 47. Section 156.800 is amended by adding paragraph (d) to read as follows:

§ 156.800 Available remedies; Scope.

* * * * *

(d) HHS may consult and share information about QHP issuers with other Federal and State regulatory and enforcement entities to the extent that the consultation and information is necessary for HHS to determine whether an enforcement remedy under subpart I is appropriate.

■ 48. Section 156.805 is amended by—

■ A. Removing ''or'' after the semicolon in paragraph (a)(6).

■ B. Removing the period in paragraph (a)(7) and adding ''; or'' in its place.

■ C. Adding paragraph (d)(3).

■ D. Revising paragraph (e)(2).

The revisions and additions read as follows:

§ 156.805 Bases and process for imposing civil money penalties in Federally-facilitated Exchanges.

* * * * *

(d) * * *

(3) HHS will deliver notice under this paragraph by either hand delivery, certified mail, return receipt requested, or by overnight delivery service with signature upon delivery required.

(e) * * *

(2) HHS will notify the issuer in writing of any penalty that has been assessed under this subpart and of the means by which the QHP issuer or another responsible entity may satisfy the CMP assessment.

* * * * *

■ 49. Section 156.806 is added to read as follows:

§ 156.806 Notice of non-compliance.

If HHS learns of a potential violation described in § 156.805 or if a State informs HHS of a potential violation, prior to imposing any CMPs, HHS must provide a written notice to the issuer, to include the following:

(a) Describe the potential violation.

(b) Provide 30 days from the date of the notice for the QHP issuer to respond and to provide additional information to refute an alleged violation.

(c) State that a civil money penalty may be assessed if the allegations are not, as determined by HHS, refuted.

■ 50. Section 156.810 is amended—

■ A. By revising paragraph (a)(6).

■ C. In paragraph (a)(9) by removing ''or'' after the semicolon.

■ D. In paragraph (a)(10) by removing the period and adding a semicolon in its place.

■ E. By revising paragraph (a)(11).

■ F. By adding a new paragraph (a)(12).

■ G. By revising paragraph (d) introductory text.

The revisions and additions read as follows:

§ 156.810 Bases and process for decertification of a QHP offered by an issuer through a Federally-facilitated Exchange.

(a) * * *

(6) The QHP no longer meets the applicable standards set forth under subpart C of Part 156.

* * * * *

(12) The QHP issuer substantially fails to meet the requirements related to the cases forwarded to QHP issuers under Subpart K; or

(13) The QHP issuer substantially fails to meet the requirements related to the offering of a QHP under Subpart M.

* * * * *

(d) *Expedited decertification process.* For decertification actions on grounds described in paragraphs (a)(6), (7), (8), or (9) of this section, HHS will provide written notice to the QHP issuer, enrollees, and the State department of insurance in the State in which the QHP is being decertified. The written notice must include the following:

* * * * *

■ 51. Section 156.1105 is amended by adding paragraphs (d) and (e) to read as follows:

§ 156.1105 Establishment of standards for HHS-approved enrollee satisfaction survey vendors for use by QHP issuers in Exchanges.

* * * * *

(d) *Monitoring.* HHS will periodically monitor HHS-approved enrollee satisfaction survey vendors to ensure ongoing compliance with the standards in paragraph (b) of this section. If HHS determines that an HHS-approved enrollee satisfaction survey vendor is non-compliant with the standards required in paragraph (b) of this section, the survey vendor may be removed from the approved list described in paragraph (c) of this section and/or the submitted survey results may be ineligible to be included for ESS results.

(e) *Appeals.* An enrollee satisfaction survey vendor that is not approved by HHS after submitting the application described in paragraph (a) of this section may appeal HHS's decision by notifying HHS in writing within 15 days from receipt of the notification of not being approved and submitting additional documentation demonstrating how the vendor meets the standards in paragraph (b) of this section. HHS will review the submitted documentation and make a final approval determination within 30 days from receipt of the additional documentation.

■ 52. Section 156.1120 is added to subpart L to read as follows:

§ 156.1120 Quality rating system.

(a) *Data submission requirement.* (1) A QHP issuer must submit data to HHS and Exchanges to support the calculation of quality ratings for each QHP that has been offered in an Exchange for at least one year.

(2) In order to ensure the integrity of the data required to calculate the QRS, a QHP issuer must submit data that has been validated in a form and manner specified by HHS.

(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the reporting level specified by HHS.

(b) *Timeline.* A QHP issuer must annually submit data necessary to calculate the QHP's quality ratings to HHS and Exchanges, on a timeline and in a standardized form and manner specified by HHS.

(c) *Marketing requirement.* A QHP issuer may reference the quality ratings for its QHPs in its marketing materials, in a manner specified by HHS.

(d) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (a) of this section to the U.S. Office of Personnel management, in the time and manner specified by the U.S. Office of Personnel Management.

■ 53. Section 156.1125 is added to subpart L to read as follows:

§ 156.1125 Enrollee satisfaction survey system.

(a) *General requirement.* A QHP issuer must contract with an HHS-approved enrollee satisfaction survey (ESS) vendor, as identified by § 156.1105, in order to administer the Enrollee Satisfaction Survey of the QHP's enrollees. A QHP issuer must authorize its contracted ESS vendor to report survey results to HHS and the Exchange on the issuer's behalf.

(b) *Data requirement.* (1) A QHP issuer must collect data for each QHP, with more than 500 enrollees in the previous year that has been offered in an Exchange for at least one year and following a survey sampling methodology provided by HHS.

(2) In order to ensure the integrity of the data required to conduct the survey, a QHP issuer must submit data that has been validated in a form and manner specified by HHS, and submit this data to its contracted ESS vendor.

(3) A QHP issuer must include in its data submission information only for those QHP enrollees at the reporting level specified by HHS.

(c) *Marketing requirement.* A QHP issuer may reference the survey results for its QHPs in its marketing materials, in a manner specified by HHS.

(d) *Timeline.* A QHP issuer must annually submit data necessary to conduct the survey to its contracted ESS vendor on a timeline and in a standardized form and manner specified by HHS.

(e) *Multi-State plans.* Issuers of multi-State plans, as defined in § 155.1000(a) of this subchapter, must provide the data described in paragraph (b) of this section to the U.S. Office of Personnel management, in the time and manner specified by the U.S. Office of Personnel Management.

PART 158—ISSUER USE OF PREMIUM REVENUE: REPORTING AND REBATE REQUIREMENTS

■ 54. The authority citation for part 158 continues to read as follows:

Authority: Section 2718 of the Public Health Service Act (42 U.S.C. 300gg–18), as amended.

■ 55. Section 158.150 is amended by revising paragraph (b)(2)(i)(A)(*6*) to read as follows:

§ 158.150 Activities that improve health care quality.

* * * * *

(b) * * *

(2) * * *

(i) * * *

(A) * * *

(*6*) Commencing with the 2012 reporting year and extending through the first reporting year in which the Secretary requires ICD–10 as the standard medical data code set, implementing ICD–10 code sets that are designed to improve quality and are adopted pursuant to the Health Insurance Portability and Accountability Act (HIPAA), 42 U.S.C. 1320d–2, as amended, limited to 0.3 percent of an issuer's earned premium as defined in § 158.130.

* * * * *

■ 56. Section 158.211 is amended by revising paragraph (a) to read as follows:

§ 158.211 Requirement in States with a higher medical loss ratio.

(a) *State option to set higher minimum loss ratio.* For coverage offered in a State whose law provides that issuers in the State must meet a higher MLR than that set forth in § 158.210, the State's higher percentage must be substituted for the percentage stated in § 158.210. If a State requires the small group market and individual market to be merged and also sets a higher MLR standard for the merged market, the State's higher percentage must be substituted for the percentage

stated in § 158.210 for both the small group and individual markets.

* * * * *

■ 57. Section 158.220 is amended by revising paragraph (a) to read as follows:

§ 158.220 Aggregation of data in calculating an issuer's medical loss ratio.

(a) *Aggregation by State and by market.* In general, an issuer's MLR must be calculated separately for the large group market, small group market and individual market within each State. However, if a State requires the small group market and individual market to be merged, then the data reported separately under subpart A for the small group and individual market in that State must be merged for purposes of calculating an issuer's MLR and any rebates owing.

* * * * *

■ 58. Section 158.221 is amended by adding paragraphs (b)(6) and (7) to read as follows:

§ 158.221 Formula for calculating an issuer's medical loss ratio.

* * * * *

(b) * * *

(6) The numerator of the MLR in the individual and small group markets in States that adopted the transitional policy outlined in the CMS letter dated November 14, 2013 must be the amount specified in this paragraph (b), except that issuers that provided transitional coverage may multiply the total incurred claims and expenditures for activities that improve health care quality incurred in 2014 in the respective State and market by a factor of 1.0001.

(7) The numerator of the MLR in the individual and small group markets for issuers participating in the State and Federal Exchanges (sometimes referred to as ''Marketplaces'') must be the amount specified in this paragraph (b), except that the total incurred claims and expenditures for activities that improve health care quality incurred in 2014 in the respective State and market may be multiplied by a factor of 1.0004.

* * * * *

■ 59. Section 158.231 is amended by revising paragraph (a) to read as follows:

§ 158.231 Life-years used to determine credible experience.

(a) The life-years used to determine the credibility of an issuer's experience are the life-years for the MLR reporting year plus the life-years for the two prior MLR reporting years. If a State requires the small group market and individual market to be merged, then life-years used to determine credibility must be the life-years from the small group market and the individual market for the MLR reporting year plus the life-years from the small group market and the individual market for the two prior MLR reporting years.

* * * * *

■ 60. Section 158.243 is amended by revising paragraph (b)(1) and adding paragraph (b)(3) to read as follows:

§ 158.243 De minimis rebates.

* * * * *

(b) * * *

(1) Except as provided in paragraph (b)(3) of this section, an issuer must aggregate and distribute any rebates not provided because they did not meet the minimum threshold set forth in paragraph (a) of this section by aggregating the unpaid rebates by individual market, small group market and large group market in a State and use them to increase the rebates provided to enrollees who receive rebates based upon the same MLR reporting year as the aggregated unpaid rebates. An issuer must distribute such aggregated rebates by providing additional premium credit or payment divided evenly among enrollees who are being provided a rebate.

* * * * *

(3) If distribution of aggregated unpaid rebates according to paragraph (b)(1) of this section would result in any enrollee(s) receiving rebates that exceed their premium paid during the MLR reporting year, or if no enrollees receive rebates based upon the same MLR reporting year as the aggregated unpaid rebates, then the issuer must not aggregate the unpaid rebates according to paragraph (b)(1) of this section and must instead distribute them according to § 158.241 directly to those enrollees whose rebates did not meet the minimum threshold set forth in paragraph (a) of this section.

Dated: March 11, 2014.

Marilyn Tavenner,

Administrator, Centers for Medicare & Medicaid Services.

Approved: March 13, 2014.

Kathleen Sebelius,

Secretary, Department of Health and Human Services.

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