



Overview of Final Exchange Regulations

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Overview of Final Exchange Rule

March 21, 2012

On March 12, 2012, the Department of Health and Human Service (HHS) issued final and interim final rules governing the Establishment of Exchanges and Qualified Health Plans; and Exchange Standards for Employers (hereinafter referred to as “the final rule” or “the regulations”) under the Patient Protection and Affordable Care Act (ACA).¹ The final rule represents the most significant guidance to date on the operation of Health Insurance Exchanges (Exchanges), setting forth the minimum standards Exchanges must meet, including those related to eligibility and enrollment into qualified health plans (QHPs) and Insurance Affordability Programs (IAPs); the minimum requirements for issuers to offer QHPs through the Exchange; and, the standards for employers to participate in the Small Business Health Options Program (SHOP). Throughout the regulation, HHS seeks to strike a balance between giving states maximum flexibility to manage the operation of Exchanges in a way that meets the needs of local markets and reflects the values of states, while simultaneously ensuring compliance with the letter and spirit of the ACA.

The purpose of this document is to provide an overview of the final rules. Section I provides a high level overview of important highlights, focusing on key areas where HHS has changed or expanded upon previous guidance. Section II provides a more detailed summary of the regulations.

I. Overview and Key Takeaways

Background on the Final Rule and Related Guidance

The final rule integrates two proposed rules related to the Exchange: (1) Establishment of Exchanges and Qualified Health Plans, issued in July 2011,² and (2) Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers, issued in August 2011³. While the rule provides substantial guidance, implementation of the Exchange eligibility provisions will require integration with the companion final regulations governing Medicaid eligibility determination and premium tax credits. The final Medicaid eligibility rule was released on March 16, 2012, following closely on the heels of the Exchange regulations. (The Medicaid eligibility final rule will be addressed in a separate analysis.) However, it appears that HHS anticipates that the final rule on premium tax credits will not be issued in tandem:

¹ CMS-9989-F, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers”. The regulations are effective 60 days after publication in the Federal Register.

² CMS-9989-P, “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans,” 76 FR 41866

³ CMS-9974-P, “Patient Protection and Affordable Care Act; Exchange Functions in the Individual Market: Eligibility Determinations; Exchange Standards for Employers,” 76 FR 51202

HHS notes in the preamble discussion that any cross-references to proposed regulatory language on premium tax credits have been replaced with the statutory references in the final regulations. The preamble indicates that HHS will incorporate the appropriate regulatory references when the IRS issues its final rule, the timing of which remains unclear.

In addition to finalizing proposed policies, the final rule includes a number of “interim final” provisions, generally where provisions in the proposed rule evolved significantly enough in response to public comment to require a new approach. Interim final rules take effect at the same time as final rules; however public comment may be submitted on interim final rules through May 11, 2012, with the possibility of HHS promulgating subsequent final guidance at a later date. The issuance of provisions on an interim final basis is by no means rare – HHS routinely takes this approach when it is at risk of noncompliance with statutory deadlines. The specific provisions that are characterized as interim final are summarized in the chart below.

Interim Final Rules	
§155.220(a)(3)	State option to permit agents and brokers to assist qualified individuals in applying for advance payments of the premium tax credit and cost-sharing reductions for QHPs
§155.300(b)	Medicaid and CHIP regulations
§155.302	Options for conducting eligibility determinations
§155.305(g)	Eligibility standards for cost-sharing reductions
§155.310(e)	Timeliness standards for Exchange eligibility determinations
§155.315(g)	Verification for applicants with special circumstances
§155.340(d)	Timeliness standards for the transmission of information for the administration of advance payments of the premium tax credit and cost-sharing reductions
§155.345(a) and §155.345(g)	Agreements between agencies administering Medicaid, CHIP and the Basic Health Plan

Establishment of a State Exchange

The regulations reiterate that a State Based Exchange (SBE) must be approved or conditionally approved by HHS no later than January 1, 2013 to offer QHPs by January 1, 2014. In order to have an Exchange approved, the state must prepare an Exchange Blueprint describing how the Exchange meets the standards laid out in this regulation and the Tax Code and confirming that the entire geographic area of the state is covered by one or more Exchanges. Thereafter, HHS will conduct a readiness assessment of the State Exchange. In a departure from the draft regulations, HHS will not model the review of a state’s initial Exchange Blueprint or future changes after the Medicaid State Plan process. When a state requests approval to make a significant change to its Exchange Blueprint, the change may be effective on the earlier of 60 days after HHS receipt of a “completed” request or upon approval by HHS. HHS may extend the review by an additional 30 days for a total of 90 days. While the time frames are precise, one

can imagine disputes between HHS and states as to when a “completed” request was received by HHS.

Federally Facilitated Exchange and Partnership Exchange

The regulations provide little specific guidance as to how the Federally Facilitated Exchange (FFE) and Partnership Exchanges (a variation of the FFE) will function, beyond confirming that if a state does not elect or is unable to establish an SBE, HHS will establish and operate an Exchange in the state. In the preamble, however, HHS does comment on the FFE and Partnership models, and many, indeed most, of the regulations related to Exchange operations, including stakeholder consultation, apply to both the FFE and SBEs. The preamble specifically reviews comments received on the Partnership Exchange, which ranged from urging HHS to minimize separation of Exchange functionality to arguing for more state options for partnering with HHS under this model. In response, HHS suggests an approach that balances state flexibility, with clear lines of responsibility and accountability between states and the federal government, and ultimately, emphasizes a seamless consumer experience. HHS reiterates prior guidance that states will have opportunities to operate plan management and consumer assistance functions in Partnership Exchanges, but does not provide a final list of functions that may be retained by states. In response to concerns about separating Exchange functionality in a Partnership Exchange, HHS reiterates that: “A seamless consumer experience is a cornerstone to an effective Exchange, and we plan to structure any Partnership in such a way that will not undermine a smooth process for individuals and employers.”

The regulations contemplate multiple areas in which the Exchange, regardless of model, may leverage existing or new federal or state resources. In all instances the Exchange and the state agency must enter into an agreement delineating their respective responsibilities and the Exchange must ensure a streamlined and coordinated process in compliance with all federal requirements. In response to concerns about accountability and blurred lines of responsibility in the Partnership Exchange, HHS notes that it does not contemplate divided authority over an Exchange. The Partnership Exchange is a variation of the FFE and the Secretary retains ultimate responsibility and authority over operations and “all inherently government functions.” A state wishing to enter into a Partnership arrangement must agree to perform the functions it assumes within the parameters articulated by HHS.

Finally, while reiterating the options available to states in partnering with an FFE, HHS also notes that in balancing flexibility and administrative feasibility, it would be extremely complicated for the FFE to implement and operate an unlimited number of variations. Where exactly HHS draws that line will, no doubt, be determined in discussions with states and articulated in future guidance.

Exchange Options for Conducting Eligibility Determinations for Insurance Affordability Programs

The regulations build on the ACA and the draft regulations offering several options by which the Exchange may rely on and coordinate with HHS and the state's Medicaid and Children's Health Insurance Program (CHIP) agencies with respect to eligibility determinations. Regardless of the option selected by a state, the regulations require the Exchange to ensure that the eligibility process for all IAPs: is streamlined and coordinated; does not increase administrative costs or the burden on applicants or enrollees; does not delay a determination or redetermination of eligibility; and, meets all requirements of confidentiality.

Delegated Responsibility. The final regulations authorize an Exchange to contract with a state agency (such as the state's Medicaid/CHIP agency) or other eligible entity to carry out one or more responsibilities of the Exchange (including the eligibility functionality). The Exchange must enter into a formal agreement with the state agency or other eligible entity and delineate the respective areas of responsibility. Ultimately, the Exchange, remains responsible for ensuring that all federal requirements are met.

Shared Responsibility. Published as an interim final regulation, a new Section 155.302 offers additional options by which an SBE may "share" responsibility for IAP eligibility determinations. Because an individual must be ineligible for Medicaid/CHIP to be eligible for advance premium tax credits (APTC) and cost sharing reductions (CSR), and the IAP eligibility process must be seamless and streamlined, it was initially assumed that an SBE would determine IAP eligibility for individuals applying through the Exchange. However, the regulations accommodate the desire of some states to rely on HHS to undertake APTC/CSR determinations and to retain responsibility for Medicaid/CHIP determinations. While reiterating the requirements for a streamlined and seamless process, the final regulations permit bifurcation of responsibility for IAP determinations through delegation of Medicaid/CHIP and/or APTC/CSR eligibility functions as follows:

- The Exchange may make an "assessment" of an applicant's eligibility for Medicaid and CHIP and, where the applicant appears eligible or desires further review, transmit the information obtained or verified to the state Medicaid/CHIP agency for final determination of Medicaid/CHIP eligibility; and,
- The Exchange may rely on HHS for eligibility determinations related to APTCs/CSRs.

Should an Exchange adopt either or both of these options, the regulations lay out specific requirements that must be met in order for the Exchange to ensure a coordinated, seamless and timely eligibility process. The regulations are clear that any bifurcation of the Exchange's eligibility responsibilities may not delay the eligibility process or result in additional burdens on the applicant or enrollee; and the Exchange remains responsible for assuring a streamlined, coordinated and timely eligibility process. It would appear that the same bifurcation of

Medicaid/CHIP eligibility would be permitted with respect to the FFE. However, in the preamble, HHS specifically notes that it intends to provide additional guidance on how these options might be implemented in the context of the Partnership model.

Individuals Potentially Eligible for Medicaid on a “Non-MAGI” Basis. The rule clarifies that the Exchange must (i) assess applicant information to determine whether an individual, not eligible for Medicaid under the modified adjusted gross income (MAGI) rules, might be eligible for Medicaid based on other Medicaid coverage groups (i.e. on a non-MAGI basis); (ii) notify applicants of their opportunity to request a determination of Medicaid eligibility on a non-MAGI basis; and, (iii) transfer to the Medicaid agency the information of any potentially eligible applicant or of any applicant who requests additional screening for a determination of eligibility on a non-MAGI basis. Thereafter, and while the application is under review at the Medicaid agency, the Exchange must process the individual’s application for APTCs/CSRs.

Verification Rules

The regulations include a number of changes to the process for verifying an applicant’s eligibility to enroll in a QHP or IAP through a combination of self-attestation, electronic data sources and in limited situations, documentation. The final regulations replace the word *may* with the word *must* to indicate where the Exchange or responsible entity is compelled to require additional information from an applicant. In all cases, the operative standard is “reasonable compatibility” which is defined for the first time in this regulation.

Timeliness. The rule requires Exchanges to determine eligibility for QHPs and IAPs “promptly and without undue delay.” In a nod to requests for more specificity, HHS notes in the preamble that it intends to release further guidance on its definition of timeliness.

Reasonable Compatibility. Under this new definition, the Exchange must consider information obtained through electronic data sources, or other information in Exchange records or provided by the applicant to be “reasonably compatible” with the applicant’s or enrollee’s attestation “if the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of premium tax credits (APTCs) or category of cost-sharing reductions (CSRs).” The preamble notes that states and Exchanges may exercise flexibility in defining what is considered reasonably compatible. “We expect that definitions will vary depending on the types of information subject to verification and that States will use this flexibility to enhance the eligibility process.” Finally, the preamble notes and the regulations confirm that the applicant’s attestation as to his or her household income and the tax return data do not have to be identical to be reasonably compatible and that where both indicate the applicant is Medicaid or CHIP eligible, such information *must* be considered reasonably compatible.

Verification Process for APTCs/CSRs. As with the proposed regulations, the final rule provides for different verification processes for applicants who are attesting to an income **increase** compared to IRS data, versus applicants who are attesting to an income **decrease** compared to IRS data. For applicant’s attesting to income increases, the Exchange must accept the

applicant's attestation if it is reasonably compatible with the IRS data and if not, the Exchange must follow the procedures for "inconsistencies" described below.

In a significant departure from previous guidance with respect to the verification process for applicants attesting to income decreases or applicants for whom tax data is unavailable, the final regulation expands the circumstances in which an applicant may use the alternate income verification process and rely on electronic data sources beyond the IRS. The final rule requires the Exchange to accept the applicant's attestation when a projected income decrease is less than 10% below the income reflected in IRS data. Where the projected income is more than 10% below the tax data or where tax return data is unavailable, the Exchange must use other income data sources. This means that if an applicant attests that his/her income is 8% below the income in the tax data, the Exchange must accept the attestation. If the individual attests that his/her income is 12% below the income in the tax data, the Exchange will examine other income data sources. Again, if the additional data do not support the applicant's attestation or such electronic data is unavailable, the Exchange must follow the procedures for inconsistencies described below.

Inconsistencies. The rule lays out the process an Exchange is to follow when it cannot verify eligibility information for QHP enrollment or an APTC/CSR, including when required electronic data is unavailable. First, the Exchange must attempt to identify the cause of the inconsistency and contact the applicant to confirm the accuracy of the information he or she submitted. Second, the Exchange must notify the applicant of the inconsistency and give him or her 90 days to present a satisfactory explanation. During this period, the applicant has a right to have his or her eligibility determined from the available data sources.

Special Circumstances Exception. The final rule also creates a new exception for special circumstances, allowing an Exchange to accept an applicant's attestation, on a case by case basis, if no documentation is available as otherwise required by the process for resolving inconsistencies described above. This exception places an emphasis on ensuring coverage and will mitigate delays in enrollment when an individual does not have documentation to reconcile an inconsistency between his or her attestation and the database verification.

Individual Eligibility Appeals

The final rules remove individual eligibility appeals from the minimum required functions of the Exchange, noting in the preamble HHS's intent to address appeals of individual eligibility determinations (including how they interact with Medicaid and CHIP appeals processes) in future rulemaking. At the same time, the rules add a new requirement that the Exchange include appeals instructions in any eligibility determination or redetermination notices.

Qualified Health Plans

Multistate plans. The final rule emphasizes that the standards and processes for certification, management and oversight of multistate plans will be defined and implemented by the U.S.

Office of Personnel Management (OPM), rather than Exchanges. Throughout the rule, HHS reiterates areas in which OPM will promulgate standards for that multistate plans, including:

- Certification, recertification, decertification of multistate plans;
- Process for considering rate increases;
- Process to submit rate and benefit data;
- Submission of transparency data; and,
- Accreditation timeline.

QHP Issuer Accreditation. The final rule reflects a potential shift in HHS thinking with regard to the Secretary's role in QHP issuer accreditation. The ACA requires that QHP issuers be accredited "by any entity recognized by the Secretary for the accreditation of health insurance issuers or plans..." HHS indicates that future rule making will articulate a process and criteria by which "accrediting entities will be recognized." This suggests that rather than identifying specific accreditation entities, the Secretary will instead articulate criteria that accrediting agencies selected by Exchanges must meet. If this interpretation is correct, it may address concerns among some stakeholders (particularly non-profit, community based, Medicaid managed care organizations that seek to enter the Exchange marketplace) that requiring QHP issuer accreditation by a Secretary-recognized entity would be resource and time intensive and create a potential "backlog" of pending accreditations among a defined and limited universe of national accreditors.

Network Adequacy. Network adequacy standards in the final rule significantly expand upon previous guidance, stating that a QHP provider network "must maintain a sufficient number and type of providers including those specializing in mental health and substance abuse to assure availability of all services without unreasonable delay." The specific reference to mental health and substance abuse services in the regulatory text and the preamble to the guidance underscores HHS's expectations with regard to both parity of and access to these benefits, particularly for traditionally underserved populations. In yet another nod to preserving state flexibility, the preamble to rule notes HHS's intent with regard to network adequacy requirements to ensure sufficient number and variety of providers in QHP networks, while maintaining Exchange flexibility to align with network adequacy standards outside the Exchange.

Essential Community Providers (ECPs). The rule clarifies the minimum requirements that Exchanges and QHP issuers must meet with regard to inclusion and reimbursement of ECPs:

- The rule clarifies that any provider that meets the criteria for an essential community provider or met the criteria on the publication data of the regulation

(unless the provider lost ECP status as a result of violating federal law) must be considered an ECP.

- A QHP issuer in an Exchange may not be prohibited from contracting with any ECP that meets the above definition. Taken together these first two requirements would effectively bar states or Exchanges from requiring QHPs to exclude from their networks specific ECPs or types of ECPs, such as Planned Parenthood clinics.
- QHP issuers must include in their provider networks a “sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to a broad range of such providers for low income, medically underserved individuals in the QHP service areas.”
- QHP issuers that provide a majority of professional covered services through employed physicians or through a single contracted medical group (i.e. group model HMOs such as Kaiser Permanente) are permitted to demonstrate their ability to provide an equivalent level of service accessibility for low-income/underserved individuals in lieu of contracting with a sufficient number of ECPs.
- QHP issuers are not required to contract with ECPs that refuse to accept “generally applicable payment rates”. At a minimum, this means that a QHP issuer is not required to pay an ECP more than it pays like providers in its network.
- A QHP issuer must pay an FQHC the relevant Medicaid prospective payment system (PPS) rate, or, alternatively, may pay a mutually agreed upon rate to the FQHC provided that such rate is at least equal to the QHP issuer’s generally applicable rate.

User Fees and Financial Support for an Exchange

The final rule provides new guidance with respect to financial support for the Exchange, including more specific guidance on the application of user fees. The final rule permits an Exchange to charge user fees of any issuer participating in a function of the Exchange and clarifies that both the FFE and SBEs may make such assessments. While not addressed specifically by HHS, this provision would appear to allow an Exchange to assess Medicaid managed care plans, Basic Health Program contracted plans, or CHIP plans to the extent these plans receive enrollments through an Exchange. The regulations do not address assessments on non-participating issuers.

Enrollment through Agents, Brokers and Private Exchanges

The final rule creates new opportunities for agents and brokers (including Web-based entities and private exchanges) to enroll qualified individuals in a QHP and assist with both QHP and IAP eligibility determinations. While an agent, broker, or Web-based entity cannot perform eligibility determinations as part of enrollment in a QHP, the rules specify that an individual can be enrolled in a QHP through the Exchange with the assistance of an agent or broker so long as the agent or broker ensures that the individual receives an eligibility determination through the Exchange. HHS notes in the preamble its intent to “provide Exchanges with discretion to leverage the market presence of agents and brokers, including web-based entities..., to draw consumers to the Exchange and to QHPs.” The regulation creates new standards and processes for these arrangements, including registration and training requirements. The rule also requires private Web-based entities enrolling individuals into QHPs through the Exchange to comply with the same standards as the Exchange website, to maintain electronic auditing records for at least ten years, and to allow applicants to opt out of the process and enroll through the Exchange at any time. It bears repeating that an individual may only access tax credits through an Exchange.

Navigators

At the same time that the final rules outline a more expansive role for agents and brokers and private exchanges, they also strengthen significantly the role of consumer groups in fulfilling the statutorily mandated Navigator function for the Exchange. These Navigator related provisions taken together with the new opportunities for producers and Web-based entities enable states to establish multiple pathways to coverage.

The final rule creates a new mandate that at least one Navigator entity operating under an Exchange must be a community and consumer-focused non-profit group. In addition, HHS clarifies in the preamble that states and Exchanges are prohibited from requiring that Navigators hold an agent’s or broker’s license, which many consumer groups have asserted would serve as a barrier to fulfilling the Navigator function. HHS reasons that such licensure requirements would, in effect, mean that only agents and brokers could serve as Navigators, and therefore would violate the regulatory requirement that at least two types of entities serve as Navigators. Finally, the final rule prohibits Navigators from receiving compensation by issuers for enrolling individuals or employees *inside or outside* of the Exchange. Earlier proposed rule making had limited this prohibition to compensation for enrollments occurring inside the Exchange. Expanding the prohibition to enrollments outside the Exchange will require agents and brokers wishing to serve as Navigators to choose between doing business with issuers outside the Exchange under traditional fee arrangements and serving those same carriers inside the Exchange with funding from Navigator grants. (The preamble notes that this does not prevent Navigators from receiving Exchange grants funded by user fees.)

Small Business Health Options Program (SHOP) Exchange

The final SHOP regulations are perhaps most interesting for the scope of fundamental Exchange design decisions that are left to individual states and Exchanges, and in some cases deferred for later federal guidance. These decisions impact employer offerings, issuer participation, employee enrollment, and group market-size determinations.

Employer Choice. In the wake of wide ranging comments on employer choice in SHOPS, the final rule continues to require that Exchanges offer qualified employers the option to select a cost sharing level, within which qualified employees may select any available QHP. HHS notes that the now final rule, which mirrors the statutory requirement, appropriately balances employee choice and SHOP flexibility to give employers greater choice. However, HHS also notes that SHOPS may go further and choose to allow choice across cost-sharing levels, or permit an employer to offer only a single plan.

Conditions of Participation and Enrollment Periods. Similar discretion is contemplated with respect to core issuer conditions of participation. While the final rule does not require an issuer to participate in both SHOP and individual Exchanges, HHS notes that an Exchange can choose to do implement such a requirement. States may also decide whether to implement a group participation rule, a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer. However, the final rule dictates that if a state does authorize such a rule it must be applied at the SHOP as opposed to issuer or QHP level. For example, a 75% participation standard is met if 8 of 10 non-waivered employees buy insurance from three different issuers under employee choice. Finally, states have the ability to supplement the list of special enrollment periods that the final rule makes applicable to SHOPS.

Employee Counting. The most fundamental element of Exchange implementation deferred to future rulemaking is the methodology for counting employees in order to determine employer market size. HHS received a number of comments on this issue, and acknowledges that there is more than one method for doing so. Because of the range of comments received, and implications beyond SHOP operation, HHS is not finalizing a rule at this time but is considering future rulemaking on the subject. HHS does confirm that sole proprietors are not eligible for SHOP participation.

Future Guidance

Finally, the final rule notes several issues that HHS intends to address through future guidance. The preamble specifically notes that separate rulemaking will address the following areas, without limitation: (1) standards outlining the Exchange process for issuing certificates of exemption from the individual responsibility policy and payment under section 1411(a)(4); (2) defining essential health benefits, actuarial value and other benefit design standards; and, (3) standards for Exchanges and QHP issuers related to quality. In addition to the above, the

preamble refers to forthcoming guidance in discussing a number of other areas ranging from financial oversight to Exchange establishment standards to eligibility and enrollment rules.

II. Summary of Regulations

The following is a summary of a number of the key provisions in the final rule issued by HHS entitled “Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Exchange Standards for Employers” (CMS-9989-F). The final rule amends Parts 155, 156 and 157 of Title 45 of the Code of Federal Regulations. The summary describes the provisions as captured in the regulatory text as well as notable discussion contained in the preamble.

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

Subpart A – General Provisions

155.20 Definitions.

Final regulations include definitions for several terms of art that are taken largely from the ACA and other existing regulations. Notably, the final rule defines three terms that were not included in the proposed rule – (1) Application Filer; (2) Exchange Blueprint; (3) Educated Healthcare Consumer – and modifies the definition of “Applicant” from the proposed rule.

“Applicant” is revised to apply to individuals who are seeking eligibility for coverage for themselves or their family, removing a reference to individuals seeking eligibility for APTCs/CSRs who might not be seeking coverage for themselves (e.g., parent seeking coverage for child only). The preamble notes this revision is to clarify that certain eligibility provisions (e.g., verification of citizenship) only apply to individuals who are seeking coverage. The term “applicant” is further clarified to include individuals seeking coverage who submit an application to an agency administering an Insurance Affordability Program (IAP) rather than directly to the Exchange and individuals who are determined eligible for Medicaid in a non-MAGI category. In response to comments, HHS also clarifies several terms in the preamble discussion.

Subpart B – General Standards Related to the Establishment of an Exchange

155.105 Approval of a State Exchange.

States electing to establish an Exchange must (1) submit to HHS an “Exchange Blueprint” describing how its Exchange meets federal standards and (2) demonstrate operational readiness through a readiness assessment conducted by HHS. Exchanges may also receive “conditional approval,” which would allow HHS to presume a state Exchange will be operational by January 1, 2014 when it is able to demonstrate progress toward, but not complete readiness for Exchange operations by the statutory HHS approval deadline of January 1, 2013. Changes in the final rule respond to concerns about unnecessary delays in Exchange implementation and future operations. The final rule notes that HHS will not model the review of Exchange plans

after the Medicaid and CHIP State Plan Process as discussed in the proposed rule. Rather than “Exchange Plan,” HHS puts forward the term “Exchange Blueprint” to reference the information submitted by a State, an Exchange, or a regional Exchange to demonstrate compliance with federal standards and operational readiness. The final rule also revises the review and approval process for changes to the Blueprint. Rather than restricting the effectiveness of proposed changes until HHS approves in writing, changes will take effect 60 days after HHS receipt of the requested change. HHS indicates that it intends to issue further guidance on the criteria for full and conditional approval of SBEs.

Finally, the regulations do not include the provision under the proposed rule that requires states to agree to perform reinsurance duties in order to secure Exchange certification.

155.106 Election to Operate an Exchange After 2014.

A more fluid picture of the timeline for state election to run Exchanges is provided in regulations than that articulated in statute: states may begin or cease Exchange operations after 2014. This does not however change the ACA requirements that: (1) a Federally-facilitated Exchange must be established in states that do not elect to operate exchanges in 2014; and, (2) Exchange establishment funding will not be awarded after 2014.

States electing to begin or terminate their Exchanges after January 1, 2014 would be required to work with federal officials to transition from or to the federally facilitated Exchange, beginning at least 12 months in advance of the change. Final regulations adopt these policies first put forth in the proposed regulations and, in the preamble discussion, HHS notes that it will further guidance on state transition planning from or to the federally facilitated Exchange. The preamble discussion also reflects that Establishment grants may be used for establishment activities that may extend beyond the first date of operation as advised in the November 29, 2011 guidance.

155.110 Entities Eligible to Carry out Exchange Functions.

Under the ACA, entities eligible to carry out Exchange functions include those entities that possess experience in providing benefit coverage for the individual and small group markets that are not insurance issuers. The statute specifically identifies state Medicaid agencies as eligible entities and the final rule broadens the list to include any state agency that is established under and subject to state law.

Regulations also provide guidance on governance and composition of Exchange boards.

- **Governance.** Exchanges that are operating as independent state agencies or not-for-profits entities must have a governing board; formal, publicly adopted operating charters or by-laws; regular public meetings announced in advance; and publicly available governance principles addressing ethics, transparency, accountability and conflicts standards.
- **Board Composition and Consumer Representation.** States are prohibited from establishing Exchange boards where a majority of representatives have conflicts

of interest. Conflicted members include representatives of insurance issuers, agents or brokers or other individuals licensed to sell health insurance. In a change from the proposed rule, the final rule notably specifies that at least one member of the Exchange's board must include a voting member representing consumers.

- **SHOP Governance.** States may create a separate governance structure for the individual and SHOP Exchanges and must ensure coordination between the separate structures.
- **HHS Review.** HHS may periodically review the accountability structure and governance principles of an Exchange.

155.130 Stakeholder Consultation.

Exchanges must regularly consult with a number of stakeholders. The ACA identifies five groups – educated health care consumers who are enrollees in QHPs; individuals and entities with experience in facilitating enrollment in health coverage; advocates for enrolling hard to reach populations; small businesses and self-employed individuals; and State Medicaid and CHIP agencies. HHS adds an additional six groups in regulations – Indian tribes; public health experts; health care providers; large employers; health insurance issuers; and agents and brokers. While HHS received comments requesting expansion of the required stakeholder groups and limitations on consultation with health insurance issuers, agents and brokers, it finalized the definition as proposed.

155.150 Transition Process for Existing State Health Insurance Exchanges.

State Exchanges operating prior to January 1, 2010 are presumed to be compliant with standards if they “insure a percentage of the population not less than the percentage of the population projected to be covered nationally after the implementation of the ACA.” In the proposed rule preamble, HHS indicated that it would apply the projected coverage level of the U.S. population in 2016 and noted two possible data sources: the CMS Office of the Actuary and the Congressional Budget Office. Regulatory text in the final rule specifies that this determination will be made using CBO estimates for projected coverage in 2016 published on March 30, 2011.

155.160 Financial Support for Continued Operations.

Beginning January 1, 2015, states must ensure that Exchanges have sufficient funding to support Exchange operations. Whereas the proposed rule prohibited use of federal Exchange establishment funds for operations after January 1, 2015, the final rule provision appears to keep the door open for states to use awarded Exchange establishment funds for operations. The final rule provision simply limits federal Exchange establishment funds from being awarded for Exchange establishment after January 1, 2015.

Assessing user fees on issuers is a specific financing method noted in the statute and carried in regulations. Comments recommended that HHS codify a number of specific parameters – such as the method for calculating assessments, notice standards, and types of issuers that may be

assessed – however HHS maintains flexibility for states in the final rule. HHS does not include additional requirements relating to imposition of user fees or other methods by which a state may generate revenue to support an Exchange. Consistent with state flexibility, HHS removes a proposed rule requirement that Exchanges announce user fees to issuers in advance of the plan year, noting in the preamble that they expect Exchanges to establish a deadline and vehicle for such announcement.

Subpart C – General Functions of an Exchange

155.200 Functions of an Exchange.

Exchanges must perform certain minimum functions relating to: eligibility for QHPs and IAPs; certification of affordability exemptions; enrollment into QHPs; financial oversight; QHP certification; and quality improvement. The final rule notably removes a proposed rule requirement that Exchanges provide appeals of eligibility determinations as a minimum function. In the preamble text, HHS cites its intent to address the content and manner of individual eligibility determinations appeals as well as specific parameters on financial oversight in future rulemaking.

In addition, the final rule clarifies that Exchanges engaging in the minimum required functions are not to be considered as operating on behalf of a QHP. This modification responds to clarification sought by commenters on the relationship between Exchanges and QHP issuers and whether Exchanges would be considered Health Insurance Portability and Accountability Act (HIPAA) “covered entities” or “business associates” of covered entities, triggering the application of HIPAA privacy and security responsibilities regarding “protected health information.” When engaging in minimum required functions, Exchanges would not be considered HIPAA covered entities or business associates; however HHS indicates that if Exchanges choose to perform functions other than, or in addition to, the minimum required functions the application of HIPAA may be triggered. As a specific example, HHS notes that states should consider whether Exchanges perform eligibility assessments for Medicaid and CHIP, based on MAGI, or conduct eligibility determinations for Medicaid and CHIP. The implication appears that if Exchanges choose to conduct eligibility determinations for Medicaid and CHIP then they would be construed as “business associates” to the states and subject to HIPAA.

155.200 Partnership Exchange

HHS does not include regulatory text, but in the preamble to the regulations discusses the option for states to establish Exchange functionality through partnership with the federal government. The preamble discussion in the final rule describes that the Partnership Exchange would be a variation of a Federally-facilitated Exchange and that HHS would have ultimate responsibility and authority over this model. HHS received comments that requested states be allowed a variety of options under the Partnership Exchange as well as comments suggesting HHS offer a standard set of limited Partnership Exchange configurations. HHS notes that it believes the options and flexibilities it has laid out (also discussed in the November 29, 2011 guidance) balances flexibility with administrative feasibility. In response to comments, HHS also clarifies that it does not believe that it is reasonable or feasible to have the Federally-facilitated

Exchange operate the SHOP component while the state operates the individual market component of the Exchange.

155.205 Consumer Assistance Tools and Programs of an Exchange

Exchanges must operate a toll-free call center and website, provide referrals to consumer assistance programs, and conduct outreach and education activities.

- **Website Content.** The final rule requires the following website content: standardized comparative QHP information (including premiums, cost-sharing, benefits summary, metal level, enrollee satisfaction, quality ratings, medical loss ratio, provider directory and certain financial and rating information); Exchange financial information (cost of required licensure, regulatory fees, or other payments; administrative costs, and losses to fraud, waste or abuse); and information about consumer assistance services (including Navigators and the call center). The website also must provide an electronic calculator to facilitate QHP comparison and allow for eligibility determinations and selection of QHPs. (The preamble notes that final QHP enrollment is effectuated by the issuer.) In the preamble discussion, HHS endorses but does not require functionality that allows users to store and access information on the website which would allow applicants, enrollees and assisters to update personal account information in the application process..
- **Accessibility Standards.** The final rule requires Exchanges to provide information in plain language and provides more detailed accessibility standards for serving individuals with limited English proficiency (LEP) and individuals with disabilities. Specifically, the final rule requires the provision of auxiliary aids at no cost for individuals with disabilities, and oral and written translations, including “tag lines” on printed material, for individuals with LEP. Finally, Exchanges must inform individuals of the availability of these services.
- **Outreach and Enrollment.** The final rule clarifies that these activities must address IAPs, which the commentary notes are intended to ensure coordination with public programs.

155.210 Navigator Program Standards

Exchanges must establish Navigator programs. The final rule further expands on the Navigator program standards rooted in the ACA.

- **Eligible Entities.** Entities that may function as Navigators include community groups, professional associations, Chambers of Commerce, unions, partners of the Small Business Administration, licensed brokers and agents, and other public or private entities that meet the standards. The Exchange must include entities from at least two of the eight categories specified. The preamble to the final rule notes that states and Exchanges are prohibited from requiring that Navigators hold an agent’s or broker’s license, including errors and omissions

insurance, because doing so would mean all Navigators are agents and brokers, thus violating the two category requirement. The final rule establishes that at least one Navigator must be a community and consumer-focused non-profit group.

- **Duties.** Navigators must maintain expertise in eligibility and enrollment (including tax implications and the cost of coverage); conduct public education activities to raise awareness about the Exchange; facilitate QHP selection; provide referrals for those with a grievance or complaints to consumer assistance programs; provide fair, accurate and impartial information; provide information in a culturally and linguistically appropriate manner; and ensure accessibility for people with disabilities.
- **Funding.** Federal Exchange establishment funds may not be used to support the Navigator grants. While regulations do not specify standards related to the required level of funding, the preamble notes that “States and Exchanges should ensure that Navigators have sufficient funds to ensure that all potential enrollees are capable of being assisted and guided in eligibility and decision-making in the Exchanges.” The preamble also notes HHS’s continued support for the use of federal Medicaid or CHIP funds to support Navigator functions related to eligibility for and enrollment into those programs.
- **Training Standards.** The final rule includes new Navigator training standards to ensure expertise in underserved and vulnerable populations, eligibility and enrollment rules, QHP options and IAPs; and privacy and security standards (to ensure the proper handling of tax data and other personal information). The preamble indicates that training standards should be available for paid and unpaid of entities serving as Navigators, and notes that training model standards will be issued in future guidance.
- **Conflict of Interest.** The final rule directs Exchanges to develop and publicly disseminate conflict of interest standards for Navigators. While not defined in regulations, the preamble states that conflict of interest “means that a Navigator has a private or personal interest sufficient to influence, or appear to influence, the objective exercise of his or her official duties.” The preamble provides examples of potential issues conflict policies may address (financial and nonfinancial considerations, family employment issues, activities with conflicted entities, disclosure practices, monitoring of enrollment patterns, legal and financial recourses, civil and criminal penalties) and notes that HHS will be releasing model conflict of interest standards in forthcoming guidance.
- **Prohibitions.** The final rule prohibits health insurance issuers, their subsidiaries or industry associations from serving as Navigators. The final rule further prohibits Navigators from receiving compensation by issuers for enrolling individuals or employees inside *or outside* of the Exchange. The preamble notes

that this does not prevent Navigators from receiving Exchange grants funded by user fees.

- **Timing, Assessments and Non-Discrimination.** While regulations do not mandate when Navigators must be operational, the preamble to the final rule encourages such programs to be available to consumers by October 1, 2013 or the start of any open enrollment period. In addition, the preamble “strongly encourages Exchanges to implement regular reviews and assessments of their Navigators.” Finally, the preamble clarifies that non-discrimination standards for Exchanges also apply to Navigators.

155.220 Ability of States to Permit Agents and Brokers to Assist Qualified Individuals, Qualified Employers, or Qualified Employees Enrolling in QHPs.

The final regulation clarifies that Exchanges have the flexibility to determine the role of agents and brokers, including web-based entities in the Exchange market place. Agents and brokers may enroll individuals directly into QHPs outside the Exchange. In addition, the final rule creates a new seamless process whereby agents and brokers may enroll individuals and employers/employees into QHPs through the Exchange and process access to APTCs/CSRs.

To provide enrollment through the Exchange the agent or broker must ensure that the applicant completes an eligibility verification and enrollment application and that the Exchange transmits the enrollment information to the QHP issuer. In addition, where an internet website of the agent or broker is used to complete QHP selection, the website must include information on all QHPs, meet all standards for disclosure and display of QHP information, not provide financial incentives, assure that the information is accessible to individuals who are limited English proficient and individuals living with disabilities, and maintain audit trails and records. The final rule makes clear that enrollment through the Exchange is the only way an individual may access APTCs/CSRs. Finally, the agent or broker must enter into an agreement with the Exchange as described below.

The rule describes two situations requiring the agent or broker to enter into an agreement with the Exchange; (1) where the agent or broker seeks to enroll qualified individuals in a QHP in a manner that constitutes enrollment through the Exchange; and, (2) where the agent or broker seeks to assist individuals in applying for APTCs/CSRs. The agreement must, at a minimum, require the agent or broker to register with the Exchange, undergo training on the range of QHPs and IAPs and comply with Exchange privacy and security standards. Finally, the agent or broker is required to comply with all state laws related to agents and brokers.

155.230 General Standards for Exchange Notices

Any notice required to be sent by an Exchange to applicants, qualified individuals, qualified employees, qualified employers and enrollees must: (1) provide three general information elements – contact for customer services resource, explanation of appeals rights (where applicable), and citation to regulatory authority and reason for intended action; (2) meet accessibility and readability requirements; and (3) be re-evaluated for appropriateness and usability. Rather than incorporate specific content, timing and format-related

recommendations into regulations, HHS explains that it would take those recommendation into consideration in its development of model Exchange notices. HHS also anticipates issuing further guidance on the coordination of notices between Exchanges, Medicaid and CHIP. The final rule removes proposed rule requirements that Exchanges re-evaluate applications, forms, and notices annually and consult with HHS when changes are made.

155.240 Payment of Premiums

Regulations specify the parameters for individual premium payments through the Exchange, while maintaining flexibility for Exchanges with respect to this function. Three options for individual premium collection by the Exchange are discussed in regulations: (1) take no part in payment of premiums (individual pays premium directly to the QHP issuer); (2) create an electronic “pass-through” without retaining any of the payments; or, (3) collect premiums from enrollees and pay an aggregated sum to the QHP issuer. In all cases, Exchanges must permit enrollees to pay premiums directly to QHP issuers. While many commented supporting a requirement that and Exchanges have the capacity for premium aggregation, HHS does not impose such a requirement and defers to state flexibility. The preamble discussion in the final rule encourages Exchanges to provide consumers with multiple payment options.

155.260 Privacy and Security of Personally Identifiable Information

The final rule removes the requirement that Exchanges establish and follow the operational, administrative, physical and technical standards required of covered entities under the HIPAA Security Rule and instead requires that Exchanges establish and implement privacy and security standards that are consistent with Fair Information Practice Principles (FIPPs). These include but are not limited to principles relating to individual access, openness and transparency and individual choice. The final rule further requires Exchanges to establish and implement operational, technical, administrative and physical safeguards that are consistent with applicable laws to ensure, among other things, that personally identifiable information (PII) is only used by or disclosed to those authorized to receive or review it. Exchanges must require the same or more stringent privacy and security standards as a condition of contract with individuals or entities such as Navigators, agents and brokers that gain access to PII submitted to an Exchange or that collect, use or disclose PII gathered directly from applicants or others while performing functions outlined in the contract with the Exchange.⁴

Civil monetary penalties of not more than \$25,000 per person or entity apply to each instance of knowing and willful improper use or disclosure of PII. Nothing in the final rule prevents or otherwise impairs the applicability of more stringent state law or other applicable federal privacy and security laws (e.g., HIPAA) to Exchanges as appropriate.

HHS expects to issue significant additional guidance, including guidance: to assist states in developing and implementing privacy and security policies and protocols and determining the applicability of HIPAA and other federal laws to Exchanges; to address breach procedures, retention of personally identifiable information; and for potential operational solutions for

⁴ This requirement does not apply to federal tax return information.

storing and tracking data, identifying and preventing fraudulent submissions to the Exchange, and de-identifying data

155.270 Use of Standards and Protocols for Electronic Transactions

Regulations codify two requirements governing electronic transactions for Exchanges: (1) where Exchanges perform electronic transactions with a covered entity, HIPAA administrative simplification standards apply; and (2) Exchanges must adopt the Health Information Technology (HIT) enrollment standards and protocols authorized under Section 1561 of the ACA within their IT systems.

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

155.302 Options for Conducting Eligibility Determinations.

Based on the comments it received, HHS adds a new interim final provision which authorizes several different models for Exchanges to carry out their eligibility functions or responsibilities at initial application as well as at redetermination. Consistent with the ACA and the proposed rule, Section 302 confirms that Exchanges may execute all eligibility functions directly or may enter into contracts with state Medicaid agencies or other entities that meet the requirements of Section 155.110 (Entities Eligible to carry out Exchange functions). Notably, Section 302 goes further than the proposed rule and relieves Exchanges of the requirement to make Medicaid and CHIP eligibility determinations, permitting Exchanges to conduct an assessment of the Medicaid/CHIP eligibility and immediately transfer the information to the state Medicaid or CHIP agency for determination. Section 302 also permits Exchanges to rely on HHS for a determination of eligibility for APTCs/CSRs. In all cases, Exchanges are responsible for ensuring that the enrollment functionality is streamlined, coordinated, does not impose additional costs or burden on applicants or enrollees, or increase delay.

- **Medicaid and CHIP.** For Exchanges that opt to assess eligibility for Medicaid/CHIP, Exchanges must apply MAGI-based income standards and immigration and citizenship status, using “verification rules and procedures” consistent with federal Medicaid and CHIP regulations, “without regard to how such standards are implemented by State Medicaid and CHIP agencies.” If the assessment finds the individual “potentially eligible” for Medicaid/CHIP, Exchanges must promptly transmit the information to Medicaid/CHIP agencies via secure electronic interface. If the assessment indicates that the application is not “potentially eligible” for Medicaid/CHIP, applicants must be given the opportunity to withdraw their applications for Medicaid/CHIP or request full determinations by the Medicaid/CHIP agencies. In the latter case, Exchanges must also proceed with the APTC/CSR determination. Exchanges and Medicaid agencies must enter into agreements delineating their respective areas of responsibility.

- **APTCs/CSRs.** Exchanges may enter into agreements with HHS whereby HHS determines eligibility for APTCs/CSRs. Exchanges must agree to submit all information to HHS via secure electronic interface, adhere to the HHS decision and provide all notices and verifications in connection with the eligibility determination in accordance with HHS rules.

155.305 Eligibility Standards.

- **a. Eligibility for Enrollment in QHP.**
The final rule describes minimum eligibility criteria for enrollment in a QHP. Individuals eligible to enroll in a QHP through Exchanges include those who are: (1) citizens, status as nationals or lawfully present immigrants; (2) not incarcerated; and, (3) living in the Exchange service area, and: (a) intend to reside, including without a fixed address; or, (b) have entered with a job commitment or are seeking employment within the Exchange service area. (The final rule aligns the residency definition to Medicaid/CHIP and add a special provision for tax households living in multiple service areas.)⁵ Individuals meeting these criteria and choosing not to pursue tax credits may be enrolled in a QHP without further inquiry.
- **b-e. Eligibility for Enrollment in Insurance Affordability Programs.**
If requested by applicants, Exchanges must determine eligibility for IAPs. Because individuals eligible for Medicaid, CHIP or a BHP are not eligible to enroll in a QHP, Exchanges are compelled to start with an eligibility review for these programs. Presumably, this section is modified by Section 155.302 discussed above, which permits Exchanges to simply “assess” and determine an individual potentially eligible or ineligible for Medicaid/CHIP.
- **f-h. Advanced Payments Of Premium Tax Credits and Cost Sharing Reductions.**
An individual is eligible for advanced payments of premium tax credits if he or she is:
 - (1) A tax filer with income between 100% and 400% of the federal poverty level (FPL)⁶;
 - (2) Claiming one or more individuals eligible to enroll in a QHP including the tax filer and their spouse; and,

⁵ A special rule for tax households with members in multiple Exchange service areas is included as an interim final provision. Any member of the household may enroll in a QHP through any of the Exchanges for which one of the tax filers meets the residency standard. If both spouses enroll through the same Exchange, a tax dependent may: (a) only enroll through that Exchange; or (b) through the Exchange where the dependent is a resident §155.305(a)(3)(iv)

⁶ Lawfully present immigrants who are ineligible for Medicaid are eligible for APTCs if their income is below 100% FPL. § 155.305(f)(2).

- (3) Not eligible for minimum essential coverage (MEC) (with the exception of coverage in the individual market) through an employer—sponsored plan or government program.

New interim final provisions clarify that individuals eligible for APTCs also will be eligible for CSRs if their household incomes are expected to be less than 250% FPL for the benefit year for which coverage is requested, *and* they are enrolled in silver level plans (different and more generous cost sharing rules apply to American Indians and Alaska Natives).⁷ Lawfully present immigrants whose incomes are below 100% FPL and who are eligible for APTCs also are eligible for CSRs. CSRs are broken down into three groups: below 150% FPL; between 150% and 200% FPL; and between 200% and 250% FPL. To the extent that enrollment in a QHP under a single policy covers individuals in different tax households, the final rule sets forth a hierarchy that an Exchange must apply in determining the appropriate category of CSRs based on the eligibility of one of the applicants in the tax household. HHS intends to issue further guidance in a number of areas, including on the “reasonably expected” standard and oversight tools and performance measurement related to eligibility and enrollment.

155.310 Eligibility Process.

- **a. Single Application.**
States must utilize either a federal model single streamlined application for enrollment into a QHP and all IAPs, or an alternative state-specific form for which the state has received federal approval. Exchanges may not request status as a citizen, national or immigrant for a non-applicant, or an individual who is not seeking coverage, on any application or supplemental form. However, new language in the final rule requires Exchanges to obtain Social Security Numbers (SSNs) for all applicants who have one. SSNs for non-applicants are required if they are tax-filers, have a SSN, and have filed tax returns that will be used for determining eligibility.
- **b. Coordination between QHP and IAP Eligibility.**
Exchanges must assess eligibility for QHP enrollment for individuals who do not seek financial subsidies through IAPs to purchase coverage. Exchanges may not, however, permit applicants to request eligibility determinations for fewer than all IAPs.
- **c-i. Exchange Eligibility Process.**
Individuals eligible for APTCs may opt to receive less than the full amount for which they are eligible. Exchanges may authorize APTCs on behalf of a tax filer

⁷ Under §155.350 of the final Exchange regulations, Indians are eligible for cost sharing reductions up to 300% FPL and an Exchange must determine an applicant eligible for the special cost-sharing rules if he or she is an Indian without requiring the applicant to request an eligibility determination.

only if the tax filer attests that he or she will file an income tax return for the benefit year, that no other taxpayer will be able to claim him or her as a dependent, and that he or she will claim a personal exemption deduction on his tax return for the applicants identified as family members.

The final rule requires written notification of eligibility determinations.

To support the employer responsibility requirements of the ACA, Exchanges must notify employers when employees are determined APTC/CSR eligible based in part on a finding that employers do not provide MEC that meets the minimum value standard and is affordable. The final rule requires that a notice be sent to the employer, disclosing only the employee's name or other personal identifier, and indicating that if the employer has more than 50 employees it may be liable for the payment assessed.

If an applicant is found eligible to enroll in a QHP, but fails to do so within the open enrollment period⁸ and later seeks to enroll, Exchanges must require the individual to attest whether or not the information affecting eligibility has changed and update his or her information accordingly before determining the individual's eligibility for an enrollment period. Where the applicant seeks to enroll on or after the date on which he would have been re-determined, Exchanges must follow procedures outlined in the annual eligibility determination in Section 155.335.

- **d-e. Eligibility Determination Timeframes.**

An interim final provision discusses new timeliness standards for eligibility determinations, requiring Exchanges to determine eligibility "promptly and without undue delay". Consistent with this requirement, when Exchanges determine individuals are eligible for Medicaid/CHIP, they must promptly and without undue delay transmit the information to the Medicaid/CHIP agencies to enable these agencies to provide the individuals with coverage. In the final rule preamble, HHS notes that it believes "it is reasonable that the majority of eligibility determinations will be completed in a very short time" and encourages Exchanges to continuously monitor and seek to shorten the eligibility time line. HHS expects to provide further guidance on timeliness standards.

155.300, 155.315(a)-(i) Verification Process Related to Eligibility for Enrollment in a QHP through the Exchange.

The final rule includes three central requirements for QHP and APTC/CSR eligibility verification processes. In a departure from the proposed rule, these requirements are more prescriptive as to when Exchanges "must" (versus "may") seek additional verification or require documentation:

⁸ 13 The open enrollment period is defined in the Exchange Final Regulations issued on March 12, 2012.

155.300 Reasonable Compatibility.

For QHP and IAP eligibility determinations, the Exchange must consider information obtained through electronic sources, other information provided by the applicant, or other information in Exchange records to be “reasonably compatible” with an individual’s attestation if “the difference or discrepancy does not impact the eligibility of the applicant, including the amount of advance payments of the premium tax credit or category of cost sharing reductions.” The preamble notes that the definition will vary depending on the types of information subject to verification.

155.315(f) Inconsistencies.

If an applicant’s attestation is found **not** reasonably compatible, Exchanges must reconcile the inconsistencies by first: (i) identifying and addressing the cause of the inconsistency (e.g. typographical or other clerical errors) by contacting the application filer; then, (ii) providing the applicant 90 days to submit “satisfactory documentation” to reconcile the inconsistency. In new language in the final rule, an applicant must be able to submit such documentation online, in person or by mail (not by telephone). Exchanges may extend the 90 day period if the applicant demonstrates a good faith effort to provide documentation. During the period when the Exchange is resolving the inconsistency, it must ensure that an APTC/CSR is provided on behalf of the applicant *if* the tax filer attests that they understand that such advance payments are subject to reconciliation. If, after the 90 days, Exchanges remain unable to verify the attestation, the applicant’s eligibility must be determined based on the information in the data sources, unless the applicant qualifies for the exception described immediately below.⁹

155.315(g) Exception for Special Circumstances.

HHS includes a new interim final provision that establishes an exception for special circumstances in which an applicant does not have documentation to resolve an inconsistency. The preamble suggests that this exception might be used for individuals who are homeless, victims of domestic violence or natural disasters or sporadic workers. Except for an inconsistency related to citizenship or immigration status, Exchanges must provide an exception “on a case by case basis, whereby it will accept the applicant’s attestation as to the information which cannot otherwise be verified along with an explanation of circumstances as to why the applicant does not have documentation.”

An Exchange must verify or obtain information as detailed below in order to determine that an applicant is eligible for QHP enrollment:

- *Social Security Number.* The final rule requires that the Exchange transmit applicant SSNs to HHS for validation through the Social Security Administration (SSA). If the Exchange is unable to validate an applicant’s SSN through SSA, it must follow the “inconsistencies” provisions specified in Subsection 155.315(f), subject to certain noticing exceptions.

⁹ It should be noted that the final rule appears to cross-reference the wrong subsection, but we believe the intent to cross reference subsection g’s exception for special circumstances.

- *Citizenship/Immigration Status.* An Exchange must verify citizenship by matching an applicant's SSN with the SSA and matching immigration status through the DHS. If the Exchange is unable to validate an applicant's citizenship or immigration status, it must follow the "inconsistencies" provisions specified in Subsection 155.315(f), subject to certain noticing exceptions.
- *Residency.* With limited exceptions, Exchanges have two options for verifying residency: (1) accept the applicant's attestation without further verification; or, (2) examine electronic data sources. If Exchanges choose to verify residency through data sources, the final rule adds new language that the sources must be approved by HHS and be sufficiently current, accurate, and minimize administrative cost and burdens. In a new clarification, evidence of residency obtained in verifying applicant immigration status may be used to verify that an applicant is a resident of the Exchange service area, but may not be used as evidence that an applicant is not a resident if such information is not consistent with the applicant's attestation. Finally, while the proposed rule required Exchanges to follow the residency verification policies of Medicaid/CHIP agencies, the final rule gives the Exchanges authority to choose a different residency verification process for QHP and APTC/CSR eligibility determination.
- *Incarceration.* The proposed rule requires Exchanges to verify through electronic data sources that applicants are not incarcerated. These data sources must be approved by HHS and be current, accurate and offer less administrative complexity than paper verification. If the applicant's attestation is not reasonably compatible with approved data sources, other information provided by the applicant, or Exchange records, the Exchange must follow the "inconsistencies" provisions specified in Subsection 155.315(f). If an approved data source is unavailable, Exchanges must accept applicant attestation.

Pursuant to the final rule, states may modify the methods used for collection of information and verification of information and the specific information required so long as HHS finds that such modifications would: reduce administrative costs and burdens on individuals, maintain accuracy, minimize delay, not undermine coordination with Medicaid and CHIP and ensure confidentiality.

The final rule prohibits Exchanges from requiring an applicant to provide information beyond the minimum necessary to support the eligibility and enrollment processes for the Exchange, Medicaid, CHIP and BHP.

155.320 Verification Process Related to Eligibility for IAPs.

The following rules apply only to applicants and tax filers requesting an eligibility determination for an IAP. The Exchange regulations § 155.320 begins with general requirements that apply to all Insurance Affordability Programs.

- **Minimum Essential Coverage (MEC)**
 Other Than through an Eligible Employer Sponsored Plan. Exchanges must determine any other non-employer coverage for which the applicant is eligible. Exchanges must verify whether applicants are eligible for MEC other than through employer-sponsored plans or Medicaid, CHIP or BHP, e.g., Veterans health coverage.
- **Household Size.**
 Exchanges verify household size using tax return data, including data regarding family size. The final rule clarifies that if an applicant attests that tax data represent an accurate projection “of a tax filer’s family size for the benefit year for which coverage is projected”, the Exchange must use family size information from tax data to determine eligibility for APTCs/CSRs. The final rule adds new language related to verifying household size if the tax data is unavailable, or the applicant attests to a change in circumstances that occurred or is reasonably expected to occur. In those circumstances, an Exchange must accept the applicant attestation of family size unless the explanation of change in circumstances is not reasonably compatible with the information provided or available in Exchange records. If the Exchange finds that the attestation of family size is not reasonably compatible, it must attempt to verify family size through other electronic data sources. If other data sources are unavailable or not reasonably compatible with the attestation, then the Exchange must request additional documentation from the applicant consistent with the “inconsistencies” provisions specified in Subsection 155.315(f).
- **Household Income.**
 Exchanges must use tax return data, to the extent that such data is available, as the basis for determining APTC/CSR eligibility. The preamble notes that the final rule is modified to clarify that Exchanges have flexibility in verification process sequencing, and may present an applicant with projected income based on tax return data for applicant attestation, or alternatively, request an applicant attestation of projected income and verify the attestation against tax data. If applicants attest that tax data accurately reflects projected income for the benefit year, Exchanges must determine the applicant’s eligibility for APTC/CSRs. The rule provides that if tax return data is unavailable, or the applicant attests that there is a change of circumstances or a change is reasonably expected to occur, Exchanges must pursue additional verification processes as described below:
- **Verification Processes for Applicants with *Increases* in Household Income.**
 If the applicant attests that their annual income has increased or is reasonably expected to increase as compared to the available tax data, an Exchange must accept the attestation without further verification unless such attestation is not “reasonably compatible” with other information provided by the applicant or

available to the Exchange. If it is not reasonably compatible, then the Exchange must use other data sources to verify the household income. If such data sources are unavailable or not reasonably compatible, then the Exchange must request additional documentation from the applicant consistent with the “inconsistencies” provisions specified in Subsection 155.315(f).

- **“Alternate Verification Process” for Applicants with *Decreases* in Household Income or Situations in Which No Tax Data Is Available.** If the applicant attests that the annual income has decreased or is reasonably expected to decrease as compared to the available tax data or there is no available tax data to verify applicant income, he or she may be eligible for an “alternate verification process.” An applicant must meet one of the following conditions to qualify for an “alternate verification process”:

- (1) the IRS does not have tax data for the applicant that is at least as recent as the calendar year two years prior to the calendar year in which APTCs/CSRs would be effective;
- (2) the applicant attests that the family size or family members have changed;
- (3) the applicant attests to a change in circumstances has occurred or is reasonably expected to occur;
- (4) the applicant attests that his/her tax filing status has changed or is reasonably expected to change to that the tax filer’s annual income has or is expected to decrease; or
- (5) an applicant in the tax filer’s family has applied for unemployment benefits.

Notably, the final rule rescinds a proposed requirement that only applicants who attest to a drop in income of 20% or more would qualify for the alternative verification process. The final rule therefore permits more individuals to access the alternate verification process than outlined in the proposed rule.

- **Alternative Verification Process for Applicants with Income Decreases of $\leq 10\%$ As Compared to Tax Data.**

If an individual qualifies for the alternate verification process (i.e. meets one of the five criteria above) and attests to projected annual income that reflects a decrease of no more than 10 percent as compared to tax data, the Exchange must accept the applicant’s attestation. HHS notes its belief that the 10% threshold will result in eligibility determinations that are accurate while limiting the administrative burden associated with completing additional verification processes for small decreases in income.

- **Income Decreases of >10% As Compared to Tax Data or No Tax Data is Available.**

If the individual qualifies for the alternate verification process and either their projected annual income reflects a decrease of more than 10% as compared to tax data, or no tax data is available, an Exchange must attempt to verify household income using alternate data sources, i.e., current income sources. If those alternate data sources are not reasonably compatible with the attestation, then the Exchange must give the applicant 90 days to provide “satisfactory documentation” consistent with the “inconsistencies” provision (Subsection 155.315(f)). If at the end of the 90 day period, the Exchange is unable to verify household income, it must determine eligibility based on tax return data (for those applicants for whom tax data is available). Finally, new language in the final rule clarifies that if the Exchange is unable to verify the household income and the tax data is unavailable, then the Exchange must find the tax filer ineligible for APTC/CSRs.

155.330 Eligibility Redetermination During the Benefit Year

In new language, the final rule prohibits Exchange from requesting change information from individuals did not apply for IAPs. The final rule also gives Exchanges a new option to establish a “reasonable threshold” for income change reporting, such that individuals with income changes below that threshold are not required to report. The preamble notes that by limiting enrollee change reporting, an Exchange can reduce both confusion for enrollees and administrative burdens on the Exchange. The final rule adds new language regarding Exchange flexibility to make additional efforts to identify and act on changes that might affect eligibility for QHPs and IAPs.

155.335 Annual Eligibility Redetermination

Exchanges must re-determine enrollee eligibility for QHP coverage annually and must request tax return data with respect to individuals receiving APTCs. Exchanges must provide enrollees with annual redetermination notices that reflect updated household income information and the enrollee’s projected eligibility for the following year, including, where applicable, the amount of any APTCs and the level of CSRs for which the enrollee is eligible.

The final rule adds language to specify that Exchanges must receive authorization from enrollees to obtain updated tax information for purposes of conducting annual redeterminations. The final rule authorizes Exchanges to obtain tax data for a period of up to five years, unless the individual declines this authorization or chooses to authorize for a period of less than five years. If an individual requests an eligibility determination for an IAP, but has not authorized the Exchange to obtain tax data as part of the annual redetermination process, the Exchange must notify the enrollee and may not proceed with redetermination until authorization has been obtained or the enrollee declines financial assistance.

The final rule adds new timing standards for the annual redetermination notice and provides that the annual redetermination notice must be combined with the annual notice of open

enrollment into a single, coordinated notice in the first two years. (Starting with redeterminations of coverage effective on or after January 1, 2017, Exchanges may send redetermination notices separate from the notice of open enrollment subject to certain requirements set forth in regulation.) Enrollees must sign and return notices online, by phone, mail or in person, within 30 days, reporting any changes relative to the information reflected on the notices.

If the enrollee fails to return the notice, Exchanges will re-determine the individual's eligibility based on the information provided in the notice.

Finally, in the preamble, HHS explains that, in accordance with comments it received, redeterminations during the benefit year will not satisfy the annual redetermination requirement.

155.340 Administration of APTCs and CSRs

Exchanges must provide information about tax filer eligibility for, including the amount of, APTCs and CSRs to their QHP and to HHS to enable advance payments.¹⁰ Where an Exchange determines that an individual is eligible for APTCs/CSRs based in part on a finding that an individual's employer does not provide affordable MEC meeting minimum value requirements, the Exchange must transmit the tax filer's name to HHS to facilitate the employer responsibility provisions of the ACA. Exchanges must further must report information to enable the Treasury to reconcile the amount of advance payments received by individuals with the amount allowed based on their tax returns.

The final rule adds a timeliness standard to these data sharing and reporting requirements, published as an interim final provision: Exchanges must transmit "promptly and without undue delay" information to enable advance payments of the premium tax credits and cost-sharing reductions.

155.345 Coordination with Medicaid, CHIP, the Basic Health Program, and the Pre-existing Condition Insurance Plan

Standards for agreements between and among Exchanges and IAPs are included as an interim final provision. The agreements must provide clear delineation of the responsibilities of each program to minimize burden on individuals, ensure prompt determinations of eligibility and enrollment, including redeterminations, and ensure compliance with this section.

The final rule clarifies responsibilities of Exchanges with respect to applicants potentially eligible for Medicaid on a non-MAGI basis. Under the final rule, Exchanges must assess the information provided by applicants on their applications to determine whether they are potentially eligible for Medicaid based on factors not otherwise considered (e.g., the individual might be eligible based on a disability screening). Exchanges must also notify applicants of the opportunity to

¹⁰ The final rule replaces the terms "applicant" and "enrollee" with "tax filer" in connection with advance payments of premium tax credits because the tax filer is the eligible person for that benefit. The rule also replaces "Social Security number" with "taxpayer identification number," in accordance with statute.

request a full Medicaid eligibility determination. The Exchange must electronically transfer any information obtained or verified concerning such applicants to the Medicaid agency, notifying the applicant of such information transmission.

For purposes of eligibility for APTCs/CSRs, Exchanges must consider individuals who are ineligible for Medicaid under the MAGI standards but are undergoing a full screening for Medicaid on a non-MAGI basis to be ineligible for Medicaid. These applicants may, but need not, enroll in QHPs pending determination of their eligibility for Medicaid.

The final rule sets forth the responsibilities of Exchanges with respect to QHP and APTC/CSR determinations for applications submitted directly to state Medicaid/CHIP agencies. Exchanges must: (1) accept, via secure electronic interface, all information provided on the application and any information obtained or verified by, the agency administering Medicaid, CHIP, or the BHP for the individual, and not require submission of another application; (2) not duplicate any eligibility and verification findings already made by the transmitting agency; (3) not request information or documentation from the individual already provided to another IAP; (4) promptly and without undue delay determine eligibility of the individual for enrollment in a QHP, APTCs and CSRs; and, (5) provide a streamlined process for eligibility determinations regardless of the agency that initially received an application.

Subpart E – Exchange Functions in the Individual Market: Enrollment in Qualified Health Plans

155.400 Enrollment of Qualified Individuals into QHPs.

Exchanges must accept QHP selections from applicants eligible for enrollment, notify QHP issuers of selections, and transmit necessary eligibility and enrollment information promptly to QHP issuers and HHS. On a monthly basis, Exchanges must reconcile information with QHP issuers and HHS.

155.405 Single Streamlined Application.

Exchanges must use a single, streamlined application to determine eligibility for: (1) enrollment in a QHP; (2) APTCs; (3) CSRs; and (4) Medicaid, CHIP or BHP. The application must be accepted online, by telephone, through the mail, or in-person. It is expected that HHS will develop a model application, however the regulations also authorize states to develop an alternative application, subject to approval by HHS. In the preamble discussion, HHS notes that it intends to issue further guidance on who serve as an “authorized representative” to file an application on behalf of an applicant and will align this definition with that of an authorized representative under Medicaid.

155.410 Initial and Annual Open enrollment Periods, 155.420 Special Enrollment Periods.

As directed under the ACA, HHS provides for initial, annual and special enrollment periods and the regulations specify timeframes and parameters for initial and annual open enrollment periods.

Initial and Annual Open Enrollment Periods. The final rule provides an extension of the open enrollment timeframe under the proposed rule and the initial open enrollment period in the final rule runs from October 1, 2013 through March 31, 2014. The majority of commenters recommended a six-month initial open enrollment period and HHS adopts this recommendation though limits the open enrollment period to March 31, 2014 to balance against adverse selection concerns. For coverage starting January 1, 2015, the final rule specifies an annual open enrollment period of October 15 through December 7. The Exchange must provide a written annual open enrollment notification between September 1 and 30 of each year, starting in 2014.

Special enrollment periods. Special enrollment periods must be provided for qualified individuals experiencing certain triggering events. The regulations outline the triggering events, which include:

- Loss of minimum essential coverage;
- Gain of a dependent due to marriage, birth, adoption or placement for adoption;
 - Gain of citizen, national or lawfully present individual status;
- Enrollment/non-enrollment in QHP unintentionally, inadvertently, or erroneously due to error, misrepresentation, or inaction of Exchange or HHS;
- Gain or loss of eligibility for premium tax credits or changes in eligibility for cost-sharing reductions;
 - Access to new QHPs as a result of permanent move; or
 - Other exceptional circumstances, in accordance with guidance from HHS.

Indians are provided with a special enrollment period under the statute, which allows them to make changes in QHP enrollment monthly. This provision is also carried in the regulations.

Regulations specify that individuals generally will have 60 days from the triggering event to modify their QHP selection. A number of comments were submitted to HHS regarding defining triggering events and when such special enrollment period will be activated. Rather than providing further regulatory definition, HHS notes in the preamble discussion that it expects to issue additional guidance on the definition of triggering events and coordination to balance between minimizing gaps in coverage and avoiding overlaps in coverage when premium tax credits are involved. The final rule does not include a proposed policy that would have restricted an individual from changing to QHPs in different metal levels unless individuals experiences a change in his/her premium tax credit or cost sharing reduction levels.

Coverage Effective Dates. The regulations also define coverage effective dates. During the initial open enrollment period, if the Exchange receives a QHP selection from a qualified individual:

- on or before December 15, 2013, coverage must be effectuated by January 1, 2014;
- between the 1st and 15th of January through March 2014, coverage must be effectuated by the 1st of the respective following month; and,
- between the 16th and 30th/31st of December 2013 through March 2014, coverage must be effectuated by the 1st of the respective second following month.

The final rule narrows the coverage effectuation timeframes from the proposed rule, which stipulated that for a QHP selection received from the 1st through the 22nd coverage must be effectuated by the 1st of the following month. However, the final rule does provide two new elements of flexibility for Exchanges require effectuation of coverage in more expedited timeframes provided all QHP issuers agree:

For QHP selections received between the 1st and 15th of the month, the Exchange may require that coverage be effectuated prior to the end of the month. Individuals receiving subsidized QHP coverage however also must be willing to waive the right to advanced payment of premium tax credits and cost sharing reductions and bear responsibility for the responsibility for the premium and cost-sharing for the first partial month.

For a QHP selection received between the 16th and the end of the month, Exchanges may require that coverage be effectuated by the first of the following month. For future annual open enrollment periods, Exchanges must ensure that coverage is effective the first day of the following benefit year.

Finally, the final rule allows Exchanges to automatically enroll individuals under parameters that HHS will specify in future guidance. HHS indicates that further guidance will address the general circumstances under which HHS will approve Exchange auto-enrollment.

155.430 Termination of Coverage.

The regulations outline parameters on the termination of QHP coverage. Individuals must be permitted to voluntarily terminate QHP coverage with adequate notice to Exchanges or QHPs. The final rule clarifies that the termination could be as a result of the individual obtaining other minimum essential coverage.

Exchanges may also initiate termination of QHP coverage, for reasons such as: ineligibility for QHP coverage; non-payment of premiums by the individual; and decertification or termination of the QHP.

In the case of voluntary termination of coverage by the individual, the effective date for the termination of coverage is either: (1) a date specified by the individual if s/he has provided a “reasonable notice,” defined as fourteen days; (2) fourteen days after the termination request without reasonable notice; (3) in fewer than fourteen days if the individual requests an earlier

termination date and the QHP issuer can accommodate it; or (4) the last day of coverage before Medicaid, CHIP or BHP coverage begins, if the individual is newly eligible for such coverage. The final rule provides more detail than the proposed rule policies which referenced a vague standard of providing notice in “a reasonable amount of time.”

In the case of Exchange- or QHP-initiated termination of coverage, coverage will end a month following notice of termination to the individual or sooner if the individual requests. The final rule clarifies that in instances of termination due to non-payment of premiums, the 90-day grace period for individuals receiving advance payments of the premium tax credits or other grace periods afforded to individuals not receiving tax credits must be exhausted.

Exchanges must establish a process to track coverage terminations and share such information with QHP issuers and HHS. HHS expects to issue additional details on the data Exchanges are expected to track.

Subpart H – Exchange Functions: Small Business Health Options Program (SHOP)

155.700 Standards for Establishment of a SHOP.

The final rule adds a definition of “group participation rule,” the requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer. Notably, per 155.705, the decision of whether to authorize such a rule(s) is granted to the SHOP. However, if a SHOP does authorize a minimum participation rate, the rate must be based on employee participation in the SHOP and not in any particular issuer or QHP.

155.705 Functions of a SHOP

Employer Choice. The final rule retains the SHOP flexibility of the proposed rule with respect to employer choice. As required by the ACA, SHOPS must allow employers to select a level in which all QHPs are made available to employees. The final rule further provides that SHOPS may permit participating employers to make one or more QHPs available to their employees through a different method. HHS received many comments on the proposed employee/employer choice provisions, ranging from those supporting additional employee choice options such as offering plans across cost-sharing levels, to comments concerned about risk selection and in favor of more limited employee choice options, and importantly notes that nothing in the ACA limits a SHOP’s ability to offer additional options, including choice across cost-sharing levels, or allowing employers to offer only one plan. With respect to various markets, the final rule provides that employees in a merged market must still have a plan that meets the small group deductible limits and coverage levels set forth in 1302(c)(3) and (d) of the ACA, and in unmerged markets may only enroll in small group market plans.

Premium Aggregation. SHOPS must provide qualified employer with a monthly bill identifying the total amount due to QHP issuers. Under the final rule, the bill must also include the portion of each employee’s premium for which the employer is responsible and the portion for which the employee is responsible. SHOPS will collect amounts due from employers and make payments to QHP issuers. The final rule adds a requirement that SHOPS maintain certain

records and other evidence of accounting procedures and practices related to premium aggregation for at least 10 years. As explained in the preamble, this recordkeeping requirement was added for purposes of conforming to individual Exchange standards.

Rate Setting. The final rule more strongly prohibits QHP issuers from changing rates during an employer's plan year and, as in the proposed rule, asserts that SHOPs must confine QHP issuer rate changes to a uniform timeframe that is either quarterly, monthly or annually.

Premium Calculator. The final rule adds a requirement that SHOPs provide a premium calculator to qualified employers that facilitates comparison of available QHPs after employer contributions. The preamble notes that HHS will provide model programming code to support states in developing the calculator.

155.710 Eligibility Standards for SHOP, 155.715 Eligibility Determination Process for SHOP

HHS finalizes the proposed eligibility standards without substantive modifications. SHOPs must permit qualified employers to purchase coverage for qualified employees. Qualified employers are small employers offering at least all full-time employees coverage in a QHP through either the SHOP in the Exchange serving the employer's principal business address, or SHOPs serving the employees' primary worksites. HHS comments that employers must meet the eligibility requirements of each SHOP in which they participate, and flags that states may have different premium calculation standards that could make it difficult to spread differences in cost due to age or location across all employees. An employee is eligible to enroll through a SHOP if the employee receives an offer of coverage from a qualified employer. To allow for fluctuations in group size, the rule provides that qualified employers do not lose eligibility solely as a result of gaining employees beyond the small employer threshold.

As for the eligibility determination process, the final rule adopts the methods and timing by which SHOPs must verify employer and individual eligibility, but adds a few more consumer protections, mainly around privacy and notice rights. SHOPs may only collect the minimum information necessary to verify eligibility, and may not perform individual citizenship verification. Consistent with the proposed rule, the overall process calls for SHOPs to accept a single employer application form and single employee form; notify the employer or employee of inconsistencies between the applications and eligibility standards; provide a 30 day period for employers to resolve inconsistencies, and provide notice of eligibility denial and appeal rights. Employees enrolled in QHPs must also be notified when their employer ceases to purchase coverage through the SHOP, and be informed of coverage alternatives.

155.720 Enrollment of Employees into QHPs under SHOP

The final rule makes only slight changes to the proposed rule. SHOPs are responsible for establishing a uniform timeline relating to employer enrollment in the SHOP and employee enrollment in QHP coverage. Activities include: determination of employer eligibility to purchase coverage in SHOP; employer selection of level of coverage and QHPs; determination of employee eligibility for enrollment in QHP coverage, and processing enrollment into selected QHPs. In response to comments, HHS clarifies that the regulation does not require issuers to participate in both the SHOP and individual Exchange, but that each Exchange can choose to

make full participation a condition of certification. The final rule clarifies that QHPs, and not SHOPs, are responsible for notifying employees of their coverage effective dates. It also directs SHOPs to retain records for 10 years, and report employer participation and employee enrollment to the IRS for tax administration purposes.

155.725 Enrollment Periods Under SHOP

Employer Enrollment Periods. The final rule retains provisions of the proposed rule specifying that the initial open enrollment period for SHOP commences October 1, 2013, and requiring the SHOP to establish a rolling enrollment process so that employers are able to enter a SHOP at any point during the year. The rolling enrollment process is intended to match the enrollment process for the small group market outside of the SHOP. An employer's plan year consists of the 12-month period beginning with the coverage effective date, and the final rule adds a requirement that employers must have at least 30 days before the end of their plan year to make SHOP participation changes for the upcoming plan year.

Employee Enrollment Periods. The final rule requires SHOPs to establish annual open enrollment periods for employees at least 30 days prior to the end of the plan year (and after the employer's annual election period). HHS further requires SHOPs to notify employees of open enrollment periods, and to allow employees who become qualified employees outside of open enrollment to seek coverage. HHS notes that the scope of employees entitled to enroll at the time they become "qualified" may include more than just new hires (e.g., employees who move from part-time to full-time status, etc.) . The final rule also extends to SHOPs the special enrollment periods applicable in individual Exchanges (with the exception of those special enrollment periods relating to a change in citizenship/legal status, or APTC/CSR eligibility), and HHS notes that states may supplement the list.

155.730 Application Standards for SHOP

The final rule prohibits SHOPs from sharing information with employers about an employee's spouses or dependents other than name, address and date of birth.

Subpart K – Exchange Functions: Certification of Qualified Health Plans

155.1000 Certification Standards for QHPs, 155.1010 Certification Process for QHPs.

Regulations outline minimum certification requirements to ensure that QHPs in all Exchanges meet quality and value standards, while allowing states to impose additional requirements tailored to local market conditions. Tracking the language of the ACA, Exchanges may only certify QHPs upon determining that the QHPs offering in the Exchange is in the interest of consumers and small employers. The final rule requires Exchanges to establish procedures for QHP certification and adds language to provide new flexibility for Exchanges to certify QHPs throughout the benefit year. (This replaces language in the proposed rule that required Exchanges to certify all QHPs in advance of the open enrollment period.) The final rule also clarifies that Exchanges must recognize as certified QHPs CO-OPs as well as multistate plans certified by and under contract with OPM. The preamble references forthcoming regulations to

be promulgated by OPM that will address the standards and processes for multistate plans. The CO-OP deeming process will also be defined in future guidance.

155.1020 QHP Issuer Rate and Benefit Information.

QHP issuers must provide Exchanges with justifications for any rate increase for QHPs prior to implementing increases and Exchanges must consider that justification in determining whether to certify or recertify a QHP. The preamble notes that the format and content of rate and benefit data submission will be clarified in future guidance. In response to comments and to the end of greater transparency for consumers, the final rule requires Exchanges to provide access to the rate increase justification posted on the issuer’s website – specifically by providing an Exchange website link to the justification. The final rule also clarifies that OPM, in its rule-making, will provide a process for rate increase consideration of multistate plans and process for plans to submit rate and benefit information.

155.1040 Transparency in Coverage (also §156.220)

The final rule requires Exchanges to collect, and QHP issuers to provide as a condition of certification, information regarding coverage transparency including information on claims payment policies and procedures, enrollment and disenrollment, denied claims, rating practices, etc. QHP issuers are required to provide and Exchanges must ensure that such information is being provided in plain language. Exchanges must also monitor whether QHP issuers have made cost-sharing information available to requesting individuals in a timely manner. The final rule clarifies that OPM will determine the process for multistate plan submission of transparency data. The preamble to the rule notes that HHS and the Department of Labor will jointly develop and issue guidance on best practices of plain language writing. HHS will also consider including sample language alerting consumers of their ability to request cost sharing information from QHP issuers in an Exchange sample website template.

155.1045 Accreditation Timeline (also §156.275)

QHP issuers must be accredited on the basis of state based performance in nine categories including: clinical quality, patient satisfaction, access, and network adequacy; the preamble notes that these standards are a minimum and Exchanges may go further. The rule requires that Exchanges must establish a uniform period following certification of a QHP within which QHP issuers must become accredited; OPM will establish an accreditation timeline for multistate plans. The preamble references future rulemaking with regard to a process and criteria by which accrediting entities will be recognized, suggesting that rather than identifying specific, recognized accrediting agencies, the HHS will identify criteria that accrediting agencies selected by Exchanges must meet.

155.1050 Establishment of Exchange Network Adequacy Standards (also §156.230)

Exchanges must ensure that QHP issuers offer networks with sufficient choice of providers. The final rule modifies network adequacy standards set forth in the proposed rule to establish a minimum network adequacy requirement, consistent with language used in the NAIC Managed Care Plan Network Adequacy Model Act, that a QHP provider network “must maintain a sufficient number and type of providers including those specializing in mental health and

substance abuse to assure availability of all services without unreasonable delay.” The preamble notes that the revised regulatory text specifically highlights mental health and substance abuse services recognizing that the essential health benefit will create new demand for these services, which have traditionally been difficult to access for low income and undeserved populations. HHS further notes that the final rule communicates its expectations with respect to the number and variety of providers in QHP networks, while maintaining Exchange flexibility to align with network adequacy standards outside the Exchange. Notably, the rule also adds new language that a QHP issuer in an Exchange may not be prohibited from contracting with any essential community provider.

155.1055 Service Area of a QHP.

Regulations require that Exchanges have a process to establish or evaluate a QHP service area to ensure that the service area: (i) covers a minimum geographical area that is at least a county, or a group of counties defined by the Exchange, unless the Exchange determines that serving a smaller geographic area is necessary, nondiscriminatory, and in the best interest of the qualified individuals and employers; and (ii) has been established in a non-discriminatory manner, meaning without regard to racial, ethnic, language or health status factors listed in PHS Act 2705(a) or other discriminatory factors. The final rule strengthens language directing Exchanges to ensure that service area standards are met, rather than simply determining whether QHPs meet such standards.

155.1065 Stand-alone Dental Plans.

Exchanges must allow stand-alone dental plans to be offered separately or as subcontractors to QHPs, provided that the dental plans offer at least the pediatric essential dental benefit articulated in the ACA. Exchanges may certify a QHP that does not offer pediatric essential dental benefits, provided that a stand alone dental plan is also offered in the Exchange. In response to commentary to the proposed rule, HHS significantly modifies its policy in the final rule to ensure consumer access, affordability and protections in stand-alone dental plans. The final rule applies the same cost-sharing limits and restrictions on annual and lifetime limits to pediatric essential dental benefits offered by stand-alone dental plans that apply to QHPs. The final rule adds a new provision requiring an Exchange consider collective capacity (in terms of solvency and provider network) of stand-alone dental plans to ensure sufficient access to pediatric dental care. Finally, the rule requires stand-alone dental plans to comply with QHP certification standards, except those standards that cannot be met because the plan covers only pediatric dental benefits.

155.1075 Recertification of QHPs, 155.1080 Decertification of QHPs.

Exchanges must establish processes for recertifying QHPs as well as decertifying QHPs that no longer meet Exchange certification requirements such that they are no longer offered. Such processes must include a mechanism for issuers to appeal Exchange decertification decisions. The rule finalizes the proposed September 15th deadline for QHP recertification; the preamble notes that this deadline provides sufficient time for issuers and Exchanges to participate in a robust recertification process, while ensuring that consumers will be fully informed of their QHP choices well in advance of the open enrollment period. The final rule is also modified to note

that multistate plans and CO-OPs are not subject to Exchange recertification and decertification requirements. The preamble discussion of the QHP decertification process notes that future rulemaking under Section 1313 of the ACA will address oversight of Exchanges with regarding to compliance with QHP recertification, decertification and other standards.

PART 156 – HEALTH INSURANCE ISSUER STANDARDS UNDER THE AFFORDABLE CARE ACT, INCLUDING STANDARDS RELATED TO EXCHANGES

Subpart A – General Provisions

156.50 Financial Support.

The final rule requires that participating issuers pay user fees, however they are structured, to support ongoing operations of an Exchange if such fees are assessed. Regulations are also modified to clarify that user fees may be assessed by the Federally Facilitated Exchange or state-based Exchanges. The term “participating issuer” in this provision is defined as “any issuer offering a plan that participates in the specific function that is funded by user fees” which may include issuers of health insurance, QHPs, multistate plans, stand-alone dental plans as well as other issuers identified by an Exchange.

Subpart C - Qualified Health Plan Minimum Certification Standards

156.200 QHP Issuer Participation Standards.

The final rule provides standards for QHP issuer participation in an Exchange including being licensed and in good standing to offer health insurance in a state, ensuring QHP compliance with essential benefits requirements, offering at least one QHP at the silver level of coverage and one QHP at the gold level of coverage, and implementing and reporting on their QHP quality improvement strategies and enrollee satisfaction surveys. The preamble notes that the QHP issuer standards are a minimum and that an Exchange may establish additional standards and/or certification criteria targeted to facilitate participation of specific issuers, such as Medicaid MCOs. The preamble further notes that quality reporting standards are deferred to a future regulation.

156.210 QHP Rate and Benefit Information.

The final rule requires that QHP rates be applicable for the entire benefit year, or for the SHOP Exchange, the entire plan year. QHP issuers must submit rate and benefit information to Exchanges, and QHP issuers must submit to an Exchange rate increase justifications and post such justifications to their websites.

156.225 Marketing and Benefit Design of QHPs.

.The final rule requires QHP issuers to comply with state marketing rules, bars use of practices that discourage the enrollment of individuals with significant health needs and codifies

statutory language prohibiting discriminatory benefit design that would discourage enrollment of individuals with significant health needs. HHS notes that state insurance departments have significant experience in monitoring health insurer marketing practices, and that Exchanges may leverage those current practices.

156.235 Essential Community Providers.

QHP issuers must include within their networks a sufficient number of essential community providers, where available, to serve low-income, medically underserved individuals. In response to solicited comments regarding how to define a “sufficient” number of essential community providers, final guidance requires each QHP network to have a sufficient number and geographic distribution of ECPs to ensure reasonable and timely access to a broad rate of such providers for low income, medically underserved individuals in the QHP service areas. The preamble notes that this preserves the balance between sufficiency of ECPs and issuer network flexibility, and that Exchanges can go further than this minimum requirement, including requiring QHPs to contract with any willing ECP. HHS intends to monitor effectiveness of this provision in ensuring ECP access and notes that it may modify its approach. Additional, noteworthy provisions related to essential community providers include:

- **b. Alternate Standard for Certain Issuers.**
The final rule includes a new provision that directs Exchanges to offer an alternate standard to the ECP requirement for plans with a majority of services furnished “in house” (e.g. staff model HMOs, integrated delivery systems). Under the alternate standard, issuers that provide a majority of professional covered services through employed physicians or through a single contracted medical group may demonstrate their ability to provide an equivalent level of service accessibility for low-income/underserved individuals. The preamble notes that HHS was persuaded by solicited comments that the ECP requirement may otherwise subvert or require alterations to business model of these issuers.
- **c. Definition of Essential Community Providers.**
The final rule clarifies that any provider that meets the criteria for an essential community provider or met the criteria on the publication data of the regulation (unless the provider lost ECP status as a result of violating federal law) must be considered an ECP. The preamble notes that the list of essential community providers in the rule is not exhaustive and not intended to exclude any other ECPs that are not specifically listed.
- **d. Essential Community Provider Rates.**
The final rule adds a new provision that interprets and implements statutory directive for “generally applicable payment rates” to ECPs. Specifically, the final rule specifies that QHP issuers are not required to contract with essential community providers that refuse to accept “generally applicable payment rates.” The preamble to the rule clarifies that “generally applicable payment rates”

mean, at a minimum, the rates offered by QHP issuers to similarly situated providers who are not ECPs.

- **e. Federally Qualified Health Center (FQHC) Rates.**

The final rule responds to solicited commentary regarding potential approaches for reconciling: (i) the ACA Section 1311(c)(2) provision that QHPs are not required to contract with essential community providers who refuse to accept the generally applicable payment rates of the plans; with (ii) ACA Section 1302(g) provision requiring QHPs to reimburse FQHCs at each facility's Medicaid PPS rate. The final rule codifies and interprets these provisions by specifying that a QHP issuer must pay an FQHC the relevant Medicaid prospective payment system (PPS) rate, or, alternatively, may pay a mutually agreed upon rate to the FQHC provided that such rate is at least equal to the QHP issuer's generally applicable rate.

156.255 Rating Variations.

The final rule codifies ACA requirements with regard to premium rating, providing that a QHP issuer may vary premiums by the geographic rating area established under section 2701(a)(2) of the PHS Act and must charge the same premium rate for health plans outside an Exchange that are substantially the same as QHPs. The preamble notes that HHS may further clarify this standard in future rulemaking. The final rule removes rating categories articulated in proposed regulatory text (individuals; two-adult families; one adult families with a child or children; and, all other families); the preamble explains that HHS anticipates implementation of section 2701(a)(1)(A) of the PHS Act will establish rating standards that apply to issuers, including issuers, on the individual and small group markets.

156.260 Enrollment Periods for Qualified Individuals, 156.265 Enrollment Process for Qualified Individuals

QHP issuers must enroll a qualified individual during the initial and annual open and special enrollment periods and abide by the effective dates of coverage established by Exchanges. The final rule also articulates standards for QHP issuers to process QHP enrollments by adding language specifying that QHP issuers may only enroll individuals in a QHP upon receiving from Exchanges: (i) notice that the individual is a qualified individual; and, (ii) information necessary to effectuate the enrollment. The final rule clarifies procedures in cases where applicants initiate enrollment directly with QHP issuers for enrollment through Exchanges by stipulating that QHP issuers must direct individuals to file applications with Exchanges or ensure that applicants have eligibility determination for Exchange coverage obtained through Exchange websites.

156.270 Termination of Coverage for Qualified Individuals

- **b. Termination Notice Requirements.** The final rule modifies QHP termination noticing requirements to require QHP issuers to provide termination notices at least 30 days prior to the last day of coverage and to specify termination effective date and reason in such notices.

- **c-g. Grace Period and Termination for Non-payment of Premium.** As required by the ACA, QHP issuer termination policies must allow for a three consecutive month grace period for enrollees receiving APTCs, provided that the consumer has paid at least one full month premium during the benefit year. The preamble to the rule notes that HHS was persuaded by commentary to modify its approach to the grace period by requiring QHP issuers to pay claims for services rendered in the first month of the grace period, but allowing issuers to pend claims in the second and third months of the grace period. HHS reasons that the statutory three-month grace period is substantially longer than current market standards, and could result in premium differences between Exchange and non-Exchange products; the final rule mitigates this issue by aligning grace period claims payment standards in and out of the Exchange. During the grace period, QHP issuers will continue to collect APTCs on behalf of enrollees, but may only retain the first month of such payments for enrollees who exhaust the grace period (returning the excess payments to the Department of Treasury). This modification is intended to limit taxpayer liability for repayment of advance payment of premium tax credits to one month for consumers who fail to pay their co-premiums. For enrollees who are delinquent in paying premiums, the QHP issuer must provide notice of premium delinquency.

PART 157 – EMPLOYER INTERACTIONS WITH EXCHANGES AND SHOP PARTICIPATION

Subpart C – Standards for Qualified Employers

This portion of the final rule essentially aligns requirements for issuers offering QHPs through SHOPS, with the SHOP standards promulgated in 155.700 et seq. Issuers must, for example, accept payment from SHOPS, adhere to SHOP timelines for rate-setting and enrollment, only apply participation rules if authorized by SHOPS, and meet applicable notice requirements.